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# DEVELOPMENTS IN AGING: 1985
## VOLUME 1

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A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 85, SEC. 19, FEBRUARY 28, 1985

**Resolution Authorizing a Study of the Problems of the Aged and Aging**

**FEBRUARY 28 (legislative day, FEBRUARY 24), 1986.—Ordered to be printed**

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# LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC, February 28, 1986.*

Hon. GEORGE BUSH,
*President, U.S. Senate,*
*Washington, DC.*

DEAR MR. PRESIDENT: Under authority of Senate Resolution 85, agreed to February 28, 1985, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1985, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1985 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

JOHN HEINZ, *Chairman.*

## SENATE RESOLUTION 85 (SECTION 19), 99TH CONGRESS, 1ST SESSION[1]

SEC. 19. (a) In carrying out the duties and functions imposed by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, and in exercising the authority conferred on it by such section, the Special Committee on Aging is authorized from February 28, 1985, through February 28, 1986, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency.

(b) The expenses of the committee under this section shall not exceed $1,159,720, of which amount (1) not to exceed $35,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

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[1] Agreed to February 28, 1984.

# PREFACE

Congressional debate over spending priorities, heightened by a $200 billion budget deficit, thrust aging issues back before the public in 1985. Social Security and Medicare once again were brought under intense scrutiny as Congress sought to allocate budget cuts as broadly as possible. When Congress finally acted to force a balanced budget with the so-called Gramm-Rudman-Hollings bill, however, it exempted Social Security from the automatic budget-cutting process and placed limits on Medicare cuts.

By removing Social Security from Gramm-Rudman, the President and many Members of Congress acknowledged that this trust-funded program does not contribute to the deficit and stands historically as one of the most popular Federal programs. Congress also recognized that eliminating cost-of-living adjustments for 1 year, as proposed, would edge more than 500,000 Social Security beneficiaries into poverty.

Budget debates surrounding old age entitlements fueled critics of aging programs who claimed the young are suffering because of profligate spending on the old. This so-called intergenerational conflict is exacerbated by newly released statistics showing poverty rates among the elderly at an all-time low, while poverty among children reached record highs. Unfortunately, this simple statistical comparison overlooks the large number of elderly who still hover just above the poverty line; the higher levels of spending by the elderly on health care; and the importance of Federal spending as a buffer against families becoming impoverished by caring for the old. What irony that on the 50th anniversary of Social Security and the 20th of Medicare, both programs came under attack for achieving what they were designed to do—reduce poverty and economic insecurity among America's seniors.

The economic well-being of older persons remains a serious concern, despite improvements in the overall poverty rate. In 1984, the elderly, with a poverty rate of 12.4 percent, were worse off than all other adults with a rate of 10.6 percent. These rates mask the pockets of poverty among the elderly population. For instance, women make up more than three-quarters of the elderly poor and their average income is only slightly more than half that of their male counterparts. Older blacks have poverty rates that are three times that of older whites; older hispanics twice the rate. These statistics are especially disturbing because we now spend more than 28 percent of the Federal budget on the elderly, and the public appears to have reached a limit in its willingness to expand funding for aging programs.

Preoccupation with Federal budget deficits and generational equity diverted attention away from the tremendous challenges posed by the aging of the baby-boom generation and an explosive growth in the oldest segment of our society. Projections of a sevenfold increase in the 85-plus age group by the year 2040 mean we must begin now to design a more coherent long-term care system. Now is the time as well to create employment opportunities for the millions of current and future seniors who want to remain employed and whose skills will be needed to maintain the Nation's economic growth. Unfortunately, little progress has been made on either of these fronts.

Economic expansion and low inflation have meant relatively stable living expenses for older Americans, even with only minimal Social Security cost-of-living increases for the second year in a row. Lower rates of increase in health care costs, in part the result of the Medicare prospective payment system, offered some financial relief for the Nation's 27 million seniors.

Lower inflation and prospective payment helped shore up the financially vulnerable Medicare system, as well. Stimulated by financial incentives to provide more efficient care, hospitals have cut waste and reduced the average length of stay by roughly 20 percent. The Medicare trust fund appears solvent at least until the end of the next decade.

But controlling cost increases came at a price—serious threats to quality health care. In 1985, the Special Committee on Aging uncovered problems of premature and inappropriate hospital discharges, unprecedented increases in demands for post-hospital care as patients are released "quicker and sicker," and a quality monitoring mechanism inadequately equipped to do the job. Further compromises on quality seem inevitable if Congress continues to cut Medicare to achieve deficit reduction and unless more powerful safeguards are implemented.

Concerns with health care for the elderly extend beyond questions of quality. Older Americans today pay as much of their annual incomes out-of-pocket for care as they did before Medicare was enacted in 1965. Prospective payment exacerbates the situation, both by shifting care to settings which require copayments, and by triggering artificial increases in hospital deductibles.

Quality poses a new concern for seniors. Yet probably the greatest concern remains an old one—the cost of long term care. Currently, government and the private sector offer little in the way of options to protect against the devastating prospects of a chronic illness. Expanding Medicare—principally an acute care program—to include long term care services seems highly unlikely given enduring budget deficits.

Private insurance companies realize the demand for long term care policies, but without accurate measures of future liability for such services, most fear to venture forward. Those who have stepped into this arena have met with only limited marketing success. Solving the enormous problem of long term care requires the cooperation of the public and private sectors—and it is a problem whose solution is long overdue.

Improving the economic well-being of the elderly will necessitate a restructuring of America's retirement income system. At present, 34 percent of the income to elderly households comes from Social Security, 21 percent from assets, and 28 percent from earnings. Private pensions are available to only one-half of workers retiring today, and only one-half of those have earned substantial benefits.

Workers are not earning more pension income because many jobs do not offer coverage, and because workers who are covered may fail to earn, or may lose, benefits when they change jobs or have low earnings. Solving these problems will require expanded pension coverage, improved benefits and assurances that funds set aside for retirement are not spent prematurely. In 1986, Congress will have the opportunity to address these retirement income policy concerns as it considers legislation to reform the tax code.

The Special Committee on Aging had a particularly productive year in 1985. The committee was involved in the deficit reduction debates as they centered around Social Security, Medicare, food stamps, housing, the homeless, mental health, and health research. The committee's investigations led to the development of many key legislative proposals. For example, our investigations into quality of care problems under Medicare led to legislation reported by the Finance Committee that would strengthen the Government's watchdog agencies (PRO's) and offer improved protections for Medicare beneficiaries. A second investigation found that as much as $1 billion a year was being wasted by Medicare, and that Medicare beneficiaries were at risk, all because of unnecessary surgery. As a result, the fiscal year 1986 reconciliation bill passed by both the Senate and House includes a provision to establish a second opinion program for certain overused procedures.

The list of committee investigations and oversight activities goes on to include review of pacemakers, organ transplants, and health care coverage for widows, the unemployed, and children. Many of these resulted in legislative recommendations to other committees. Our review of the costs associated with keeping ventilator-dependent patients in hospitals, for example, resulted in legislation which would allow ventilator services at home, bringing savings to the government and happiness to the lives of these unfortunate individuals.

The committee's work extends beyond investigations and legislative recommendations. In the past year we continued to inform the public through committee prints, newsletters, and public hearings focused on the most pressing issues before the Congress. On the 50th anniversary of Social Security, the committee organized a symposium and published a print intended to help restore public confidence in this vital program. In areas of research, the committee reported on the health of older workers and the innovative personnel practices of companies who hire older workers. The committee produced demographic studies of America in transition to an older society and analyses of census data to determine how older Americans live. Each of these has helped to destroy myths and illustrate unmet needs.

The report that follows discusses developments of importance to older Americans in 1985. In line with changes implemented in 1984, the report surveys only Federal policies and programs and focuses exclusively on the major policy issues facing Congress and the legislative activity on these issues in 1985. Demographic data is now issued as Volume III. These and other changes are intended to make this report more informative and easier to use.

We are proud to acknowledge the dedicated work of the authors of this report, the staff of the Special Committee on Aging. This report is a synthesis of the extensive working knowledge they bring to the committee.

The graying of America presents us with significant challenges and opportunities. Providing for an ever-larger older population with fewer resources will be only one of those challenges. Ensuring high quality and accessible health care, adequate housing, and social services will require the utmost in creativity and boldness. But America's seniors are not just consumers of resources; with ample opportunity they can contribute even greater amounts to the Nation's productivity. Our challenge is to expand those opportunities and to ensure that the promise of long life is worth living.

JOHN HEINZ,
*Chairman.*
JOHN GLENN,
*Ranking Minority Member.*

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# DEVELOPMENTS IN AGING: 1985

## VOLUME 1

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FEBRUARY 28 (legislative day, FEBRUARY 19), 1986.—Ordered to be printed

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Mr. HEINZ, from the Special Committee on Aging, submitted the following

# REPORT

[Pursuant to S. Res. 85, 99th Cong.]

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# Part I

# RETIREMENT INCOME

Budget deficit reduction and tax reform dominated the legislative agenda in the Congress in 1985, although significant legislation was enacted in neither area during the year. Throughout the year, the prospects for passage of a budget reconciliation bill and a tax reform bill appeared to ebb and flow like the tides. Finally, in December a conference of the House and Senate agreed on fiscal year 1986 budget reconciliation legislation and the House passed a tax reform bill, deferring final approval of both until 1986. At the same time, Congress enacted the Balanced Budget and Deficit Control Act of 1985 [Public Law 99-177]—so-called Gramm-Rudman—setting in motion an entirely new budget process.

Retirement income issues in 1985 reflected the concentration of the Congress on broad budget and tax policy questions. Social Security's contribution to deficit reduction and its role in the Federal budget and public debt were hotly debated issues throughout the year. An attempt early in the year to include a freeze in Social Security's annual cost-of-living adjustment (COLA) in the congressional budget resolution nearly blocked agreement on fiscal year 1986 budget targets. This led, in the fall, to a campaign to accelerate Social Security's scheduled 1993 separation from the Federal budget. With enactment of the Gramm-Rudman budget reform bill, Congress separated Social Security from consideration in future budget resolutions and reconciliation bills. The delay in a necessary increase in the debt ceiling caused by the debate over Gramm-Rudman led the Treasury to make a controversial disinvestment of Social Security trust funds to pay November benefits. This withdrawal ended the year with a review of Social Security's relationship to the debt ceiling.

Budget and tax reform legislation also provided an opportunity to bring private pension concerns to the attention of the Congress in 1985. The key pension topics were the funding and reform of the insurance program that protects pension benefits when plans are terminated, and expansion of coverage and improvement of benefits. Legislation to fund and reform the single-employer termination insurance program had been before the Congress since 1982. However, the inclusion of a premium increase in the President's fiscal year 1986 budget request gave the effort to reform this program new momentum. Reform legislation was added to the budget reconciliation legislation and agreed upon by the conference committee of the House and Senate before the end of the year.

Concern about the fairness of the distribution of pension benefits and about the future adequacy of pension income was reflected in the tax reform proposal submitted to the Congress by the President in May. In addition, a growing interest in formulating a cohesive national retirement income policy emerged through several hearings on the subject in the House and Senate. Pension changes to improve fairness and reduce tax expenditures were included in the House-passed tax reform bill and will be considered by the Senate in 1986. At the same time, legislation setting forth a proposal for a national retirement income policy has also been placed before the Congress.

Increasingly, Federal spending on retirement income has become a focus of attention in the annual budget debate. Despite the exemption of most of this spending from Gramm-Rudman's automatic cuts, the pressure from Gramm-Rudman to eliminate the more than $200 billion Federal budget deficit by 1991 has already forced COLA freezes in Federal civilian and military retirement, and will force a continuing re-examination of our spending for other retirement programs in the years to come.

# Chapter 1

# SOCIAL SECURITY—RETIREMENT AND DISABILITY

## OVERVIEW

In 1985, the focus of attention in Social Security continued its shift from the short term financing problems which dominated the 1980–83 period to a growing concern with Social Security's relation to the Federal budget and long term financing outlook. Congress also continued its concern with a variety of issues that have surfaced regarding SSA's administration of its programs.

The most noteworthy event in 1985 was the involvement of Social Security in deficit reduction efforts. The year began with a proposal in the Senate Budget Committee to skip the 1986 Social Security cost-of-living adjustment [COLA]. The Senate later adopted a budget which included the Social Security COLA "freeze" by a one-vote margin. The freeze was rejected, however, in House-Senate Conference on the budget. By fall, there was new interest in separating Social Security from the Federal budget and budget process; and this was accomplished as part of the Balanced Budget and Emergency Deficit Control Act of 1985, the so-called Gramm-Rudman-Hollings Act [Public Law 99–177]. The action by Congress was fueled by two separate factors. First, since 1981, all Government programs, including Social Security, have come under consistent budget-cutting pressures, which in the case of Social Security have usually taken the form of COLA freeze measures contained in the administration's proposed budgets. Second, fears arose that the growing surpluses in the Social Security trust funds would complicate efforts to balance the Federal budget.

Separation from the budget process was finally accomplished as part of the Gramm-Rudman-Hollings Act. This new budget process protects Social Security from program cuts, COLA cancellations, and other changes included in budget reconciliation bills.

With the decline of concern over funding problems, increasing attention was focused on criticism of the management of the Social Security Administration. Problems which received the most attention included the closing of SSA field offices, staff reductions, recovery of excess benefit payments, and mismanagement of computer contracts.

Activity regarding the Disability Insurance [DI] program also experienced a shift in emphasis during 1985. Strong opposition to SSA's 1981 policy of periodic review of disability cases resulted in passage of the Social Security Disability Benefits Reform Act of 1984, which has changed the basis for continued eligibility for disability benefits. In response to the act, SSA spent 1985 developing new rules and procedures for implementing the changes. Most of the new rules did not go into effect until late 1985, so evaluation of the rules and their effect will not take place until 1986. Several issues will almost certainly arise as the year unfolds, including the following: What role will the courts play in the review of previously denied cases; how will SSA handle the backlog of cases that has built up; and what percentage of cases will be terminated under the new rules?

Social Security was also greatly affected by the Gramm-Rudman-Hollings Act in the sense that it was spared from the drastic effect of the automatic program cuts that may take place under the act. This action reinforced Social Security's identity as a stable, dependable system designed to meet a variety of high priority needs.

## A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

### 1. Background

#### (A) HISTORY AND PURPOSE

Enacted in 1935, the Social Security Program was designed to begin as a modest program with a relatively low tax rate and grow in stages until it reached maturity in the 1980's. As its architects anticipated, Social Security has only recently come of age, with the first generation of lifelong contributors retiring and beginning to draw benefits. While Social Security has expanded and changed substantially over the course of its development, the basic principles which guided the framers of the old-age pension program in 1935 have remained unaltered.

The design of Social Security reflects a compromise among a variety of purposes. This compromise is both a key to the program's broad-based political support and a cause of much of the criticism it receives. For while Social Security provides a mixture of insurance protection, earned pension benefits, and minimally adequate income in old age, it must make separate concessions in the value of each to achieve a combination that works. One current method of criticizing the program has been to evaluate the quality of benefits from only one perspective. For instance, many point to the possibility that rates of return on Social Security taxes paid by the highest wage earners may, in the long run, compare poorly with the rates of return on private investments. While it may be popular when discussing Social Security with a younger worker to focus on only one aspect of the system, this results in a distorted evaluation of the larger purposes of Social Security.

To ensure an accurate picture of the program, there are a number of features that should be factored into any equation which attempts to measure the value of Social Security.

First, Social Security provides younger workers with protection from the unpredictable and random costs of financial support for their own aged parents and relatives. The pay-as-you-go financing for Social Security, seen from this perspective, uses periodic payments by younger workers to insure their own earnings against the cost of parental support. By spreading these costs across the working population, younger workers have a smaller, fairer, and more predictable financial burden, and their parents have a degree of financial independence. This aspect of the program justifies universal coverage, since exemptions from coverage permit individuals to pass to others the costs of supporting their own parents. It also justifies features which will provide adequate retirement and survivors benefits, so that younger workers will be fully protected from having to supplement the incomes of their relatives.

Second, Social Security provides workers and their families with a "floor of protection" against sudden loss of their earnings due to their own death, disability, or retirement. This insurance is intended to protect only a portion of the income needed to preserve the previous living standard of the worker and his family, and is to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker. Receipt of benefits is based on the occurrence of an insured-against event, such as retirement, which is determined by comparing the individual to some "test" or standard, such as the retirement or earnings test. Should the individual meet the test, benefits are then provided regardless of any income from other sources.

Third, Social Security provides the individual wage earner with a basic pension benefit upon retirement. Social Security benefits, like those provided separately by employers, are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than workers with low earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating service credits. This mixture of features in Social Security has been the source of public confusion about the program over the years. The similarities between Social Security and a pension, for example, have led many people to believe that the system is funded, as a private pension might be, through workers' contributions invested in a trust fund account and used to pay benefits in the future. Others focus on the rate of return on contributions—as if Social Security were a form of individual investment.

A program with the essential social functions and multiple purposes of Social Security defies comparison with other financial or insurance vehicles. While a particular vehicle, such as an individual retirement account (IRA), may perform one function more successfully for some than does Social Security, no single vehicle could perform the unique combination of functions without approximately Social Security in its features. Most criticisms of Social Security, therefore, readily translate into criticisms of its mix of functions. For example, some critics believe Social Security ought to be only a pension plan, leaving the insurance and intergenerational support functions to specially tailored alternative programs. Others argue that Social Security should be a welfare program, providing basic benefits to the poor, and allowing middle and upper income workers to invest their earnings in private vehicles, such as IRA's. Though the use of separate programs would eliminate the compromises entailed in Social Security, it could also raise tremendously the total cost of performing all of Social Security's functions, and most likely jeopardize the widespread political support that has developed for the program.

The Social Security Program, which was created during the Great Depression, is only now becoming a mature social insurance program. The decade of the 1980's marks the first generation of lifelong contributors retiring and beginning to draw benefits. Also during this decade, it is expected that payroll tax rates, eligibility requirements, and the relative value of monthly benefits will finally stabilize at levels reasonably close to those planned for the system.

### (B) PROGRAM CHARACTERISTICS

The national old-age, survivors, and disability insurance (OASDI) program, commonly referred to as Social Security, is the largest and most important income maintenance program in the United States. Based on social insurance principles, the program provides monthly cash benefits designed to replace, in part, the income that is lost to workers or their families when the worker retires in old age, becomes severely disabled, or dies.

In October of 1985, about 36.9 million people received $15.4 billion in monthly benefits. Retired workers, numbering about 22.3 million, received monthly payments averaging $426. Disabled workers, numbering 2.7 million, received monthy payments averaging $469. Widows, widowers, surviving children, and other dependents, numbering 11.9 million, made up the balance of the recipients. Widows and widowers received an average benefit of $417. Survivors and other dependents received an average benefit of $320.

Funding for the Social Security system comes from payroll taxes paid by virtually all employers and employees in the country. In 1985, about 123 million workers were engaged in covered employment, representing about 95 percent of the jobs in the country. Social Security taxes flow into two trust funds: the Old Age and Survivors Insurance Trust Fund (OAS), and the Disability Insurance Trust Fund (DI). Other portions of the payroll taxes fund the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund. The combined OAS and DI taxes now amount to 11.4 percent of the first $42,000 of payroll, paid in equal parts by the employer and employee. In 1988, the tax rate will rise to 12.12 percent. In 1990 it will become 12.4 percent. Self-employed persons now pay 11.4 percent of their earnings in Social Security taxes. This figure will rise to 12.12 percent in 1988, and 12.4 percent in 1990. The taxable wage base will also rise proportionately with the average annual wage.

The Social Security trust funds currently take in more in taxes than they pay in benefits. At the end of September 1985, the balance in the two funds stood at $39.7 billion, an increase of $7.5 billion over September 1984.

### (C) FINANCING

#### *(1) Financing History*

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to meet any disruptions in expenditures or income due to unforeseen economic fluctuations. When Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's: Relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecasted. High levels of inflation and slow wage growth increased expenditures in relation to income. The Social Security Amendments of 1972 had not only increased benefits by 20 percent across-the-board, but also indexed automatic benefit increases to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to comparatively lower real wage growth. Further, the recession of 1974–75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "over-indexing" benefits for certain new retirees, and thereby created an additional drain on trust fund reserves.

Congress responded to the financing problem first by enacting the Social Security Amendments of 1977. Again, however, the economy did not perform as well as predicted, and the long term deficits remained. Subsequently, at the end of 1981, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a feasible solution to Social Security's financing problem. The Commission was given a year to develop a consensus approach to financing the system.

By the end of 1981, OASI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1½ months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and in December was forced to borrow $17.15 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

At the beginning of 1983, Congress moved quickly to enact legislation to restore financial solvency to the OASDI trust funds. This comprehensive package improved financing by $166 billion between 1983 and 1989, and eliminated a deficit which had been expected to average 2.1 percent of payroll over the next 75 years.

The Commission's recommendations split the near-term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions for new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI Program resulting from the 1983 Social Security amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. Key provisions include:

*Coverage.*—All Federal employees hired after January 1, 1984, were covered under Social Security, as were all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments were prohibited from terminating coverage under Social Security.

*Benefits.*—COLA increases where shifted to a calendar year basis, with the July 1983 COLA delayed to January 1984. A special feature was added to calculate the COLA on the lesser of wage or price index increases in the event that trust fund reserves are depleted.

*Taxation.*—One-half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual and $32,000 for a couple—was made subject to income taxation, with the additional tax revenue funneled back into the retirement trust fund.

*Payroll taxes.*—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

*Retirement age increase.*—An increase in the retirement age from 65 to 67 was passed to be gradually phased in between the years 2000 to 2022.

The 1983 amendments have resulted in a major improvement in the condition of the OASDI trust funds. Based on intermediate assumptions, it is expected that reserve ratios will increase from a low of 11 percent of annual outgo at the beginning of 1983 to 50 percent of outgo by the beginning of 1989. These reserves should be sufficient to continue uninterrupted benefit payments throughout the decade, and repay the HI trust fund for previous loans.

### *(2) OASDI—Near-Term Financing*

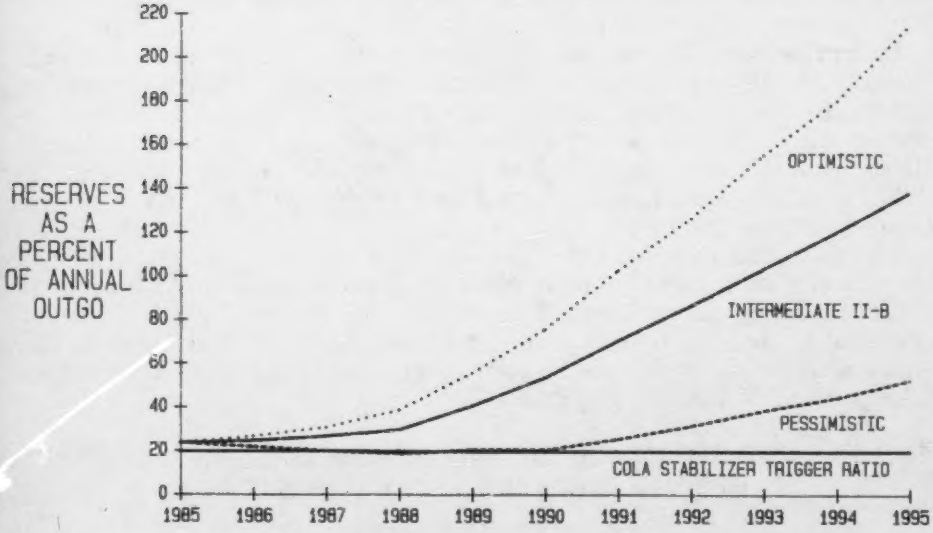
The recent economic recovery, which brought lower inflation and lower unemployment rates than anticipated has heightened the ameliorative effects of the 1983 amendments. In the short term, OASDI funds are anticipated to increase steadily each year under all but the most pessimistic assumptions employed by Social Security actuaries. Even under pessimistic assumptions, reserve ratios are expected to decline slightly, and then increase again in 1989. The trust funds should continue to grow faster than anticipated by the 1983 legislation, although some of this improvement may be limited by an expansion in DI Program costs, due to legislation enacted in 1984.

Despite favorable economic performance, some argue that the short-term financing of Social Security does not leave a large enough buffer against unforeseen economic downswings, and that additional financing measures may be necessary to guarantee continued solvency.

Overall, the truly critical years in which reserves are slim are those between the present and 1988, when a major payroll tax increase goes into effect, and reserves will build rapidly. In the period prior to 1988, under intermediate assumptions, the 1985 Social Security trustees report predicts that reserves should remain between 24 and 30 percent of projected outgo. Under pessimistic assumptions, reserves will drop to a low of 19 percent in 1988. Although the trustees consider their assumptions conservative, it is plausible to consider more pessimistic scenarios that predict an imminent financing crisis. However, this possibility seems unlikely.

CHART 1-1

OASDI RESERVE RATIOS UNDER ALTERNATIVE ASSUMPTIONS
1985 - 1995



Source: 1985 Report of the Trustees of the OASDI Trust Funds

TABLE 1.—COMBINED OASDI RESERVE RATIOS AS A PERCENTATGE OF ANNUAL OUTGO UNDER ALTERNATIVE ASSUMPTIONS: 1985–1995

| Calendar year | Optimistic | Intermediate II–B | Pessimistic |
|---|---|---|---|
| 1985 | 24 | 24 | 24 |
| 1986 | 27 | 25 | 22 |
| 1987 | 31 | 27 | 20 |
| 1988 | 39 | 30 | 19 |
| 1989 | 56 | 41 | 21 |
| 1990 | 76 | 54 | 21 |
| 1991 | 103 | 71 | 26 |
| 1992 | 127 | 87 | 32 |
| 1993 | 156 | 104 | 39 |
| 1994 | 181 | 121 | 45 |
| 1995 | 216 | 139 | 53 |

Source: 1985 Trustees report, p. 70.

### *(3) OASDI—Long-Term Financing*

In the long run, the Social Security trust funds appear to be in close actuarial balance, meaning that over the next 75 years, it is projected that the taxes collected for Social Security will fall within plus or minus 5 percent of the amount needed to pay benefits. Under current projections based on intermediate assumptions, the trustees predict that the trust funds will remain solvent throughout the next 75 years.

Although the OASDI trust funds remain healthy, under forecasts for the long term, it should be emphasized that the trust fund experience in each of the three 25-year periods between 1985 and 2060 varies considerably. In the first 25-year period—1985 to 2009—the trust funds are expected to accumulate rapidly, and remain an annual surplus of revenues equal to 2.40 percent of taxable payroll. As a result of these surpluses, OASDI reserves are expected to build to over 250 percent of an annual outgo by the year 2000.

In the second 25-year period—2010 to 2034—the financial condition of OASDI is expected to continue improving in the early years, but begin deteriorating toward the end of the period. Trust fund reserves are expected to grow over 500 percent of annual expenditures by 2015, and then decline, reaching 343 percent of outgo by 2035. The average surplus during this period will be only 0.72 percent of taxable payroll.

The third 25-year period—2035 to 2059—is expected to be one of continuous deficits. Program costs will grow until 2035 and level off, remaining above annual revenues. By the end of this period, continuing deficits are expected to have depleted the trust funds. Annual deficits over the 25-year period are expected to average 1.16 percent of taxable payroll.

TABLE 2.—COMPARISON OF ESTIMATED COST RATES AND INCOME RATES OF THE OASDI PROGRAM, ON THE BASIS OF ALTERNATIVE II–B, CALENDAR YEARS 1985–2060

[As a percentage of taxable payroll]

| Calendar year | Cost rate | | | Income rate | | | Balance |
|---|---|---|---|---|---|---|---|
| | OASI | DI | Total | Payroll tax | Taxation of benefits | Total | |
| Alternative II–B: | | | | | | | |
| 1985 | 10.10 | 1.19 | 11.29 | 11.40 | 0.21 | 11.61 | 0.32 |
| 1986 | 9.98 | 1.11 | 11.09 | 11.40 | .22 | 11.62 | .53 |
| 1987 | 9.97 | 1.08 | 11.05 | 11.40 | .24 | 11.64 | .59 |
| 1988 | 9.97 | 1.06 | 11.04 | 12.12 | .26 | 12.38 | 1.34 |
| 1989 | 9.95 | 1.05 | 11.00 | 12.12 | .28 | 12.40 | 1.41 |
| 1990 | 10.03 | 1.04 | 11.07 | 12.40 | .31 | 12.71 | 1.64 |
| 1991 | 10.01 | 1.03 | 11.04 | 12.40 | .34 | 12.74 | 1.70 |
| 1992 | 10.00 | 1.03 | 11.03 | 12.40 | .37 | 12.77 | 1.74 |
| 1993 | 9.98 | 1.03 | 11.01 | 12.40 | .40 | 12.80 | 1.78 |
| 1994 | 9.96 | 1.04 | 11.00 | 12.40 | .43 | 12.83 | 1.83 |
| 1995 | 9.81 | 1.05 | 10.86 | 12.40 | .40 | 12.80 | 1.94 |
| 1996 | 9.65 | 1.07 | 10.72 | 12.40 | .40 | 12.80 | 2.08 |
| 1997 | 9.47 | 1.08 | 10.55 | 12.40 | .39 | 12.79 | 2.24 |
| 1998 | 9.26 | 1.09 | 10.35 | 12.40 | .39 | 12.79 | 2.44 |
| 1999 | 9.11 | 1.10 | 10.21 | 12.40 | .39 | 12.79 | 2.57 |
| 2000 | 9.04 | 1.12 | 10.17 | 12.40 | .39 | 12.79 | 2.62 |
| 2001 | 8.98 | 1.15 | 10.13 | 12.40 | .39 | 12.79 | 2.66 |
| 2002 | 8.93 | 1.18 | 10.11 | 12.40 | .39 | 12.79 | 2.68 |
| 2003 | 8.88 | 1.21 | 10.09 | 12.40 | .39 | 12.79 | 2.70 |
| 2004 | 8.84 | 1.25 | 10.09 | 12.40 | .40 | 12.80 | 2.70 |
| 2005 | 8.83 | 1.29 | 10.12 | 12.40 | .40 | 12.80 | 2.67 |
| 2006 | 8.86 | 1.34 | 10.20 | 12.40 | .41 | 12.81 | 2.61 |
| 2007 | 8.91 | 1.38 | 10.29 | 12.40 | .41 | 12.81 | 2.52 |
| 2008 | 8.98 | 1.42 | 10.40 | 12.40 | .42 | 12.82 | 2.42 |
| 2009 | 9.11 | 1.46 | 10.56 | 12.40 | .43 | 12.83 | 2.27 |
| 2010 | 9.26 | 1.48 | 10.74 | 12.40 | .44 | 12.84 | 2.10 |
| 2015 | 10.38 | 1.60 | 11.98 | 12.40 | .51 | 12.91 | .93 |
| 2020 | 11.85 | 1.66 | 13.51 | 12.40 | .59 | 12.99 | −.52 |
| 2025 | 13.17 | 1.74 | 14.90 | 12.40 | .67 | 13.07 | −1.83 |
| 2030 | 14.01 | 1.69 | 15.70 | 12.40 | .73 | 13.13 | −2.57 |
| 2035 | 14.25 | 1.64 | 15.89 | 12.40 | .76 | 13.16 | −2.73 |
| 2040 | 14.06 | 1.65 | 15.71 | 12.40 | .77 | 13.17 | −2.54 |

TABLE 2.—COMPARISON OF ESTIMATED COST RATES AND INCOME RATES OF THE OASDI PROGRAM, ON THE BASIS OF ALTERNATIVE II-B, CALENDAR YEARS 1985-2060—Continued

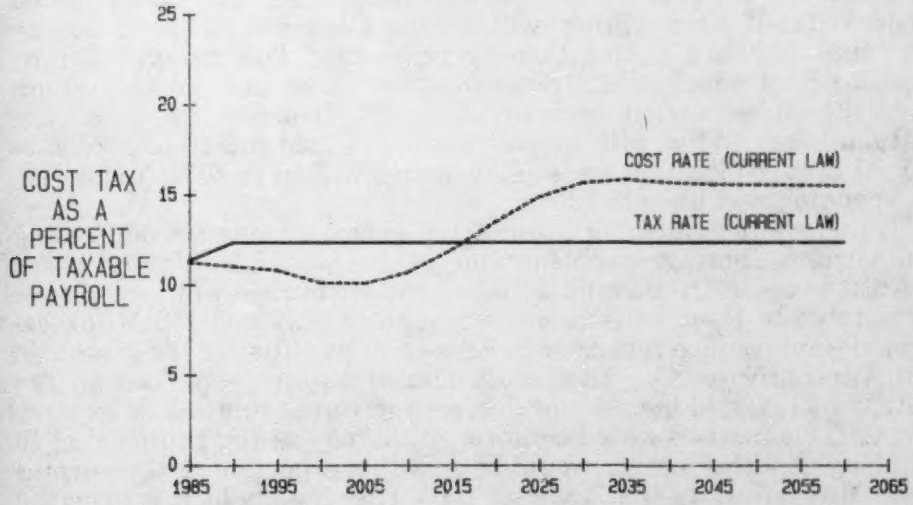
[As a percentage of taxable payroll]

| Calendar year | Cost rate |  |  | Income rate |  |  | Balance |
|---|---|---|---|---|---|---|---|
|  | OASI | DI | Total | Payroll tax | Taxation of benefits | Total |  |
| 2045 | 13.90 | 1.70 | 15.59 | 12.40 | .78 | 13.18 | −2.41 |
| 2050 | 13.88 | 1.70 | 15.58 | 12.40 | .78 | 13.18 | −2.40 |
| 2055 | 13.86 | 1.69 | 15.55 | 12.40 | .78 | 13.18 | −2.37 |
| 2060 | 13.83 | 1.69 | 15.51 | 12.40 | .78 | 13.18 | −2.33 |
| 25-year averages: |  |  |  |  |  |  |  |
| 1985–2009 | 9.46 | 1.15 | 10.62 | 12.26 | .36 | 12.62 | 2.00 |
| 2010–2034 | 12.14 | 1.65 | 13.79 | 12.40 | .61 | 13.01 | −.78 |
| 2035–2059 | 13.96 | 1.68 | 15.64 | 12.40 | .78 | 13.18 | −2.46 |
| 75-year average: |  |  |  |  |  |  |  |
| 1985–2059 | 11.85 | 1.49 | 13.35 | 12.35 | .58 | 12.94 | −.41 |

Source: 1985 Trustees report, p. 64.

CHART 1-2

ESTIMATED OASDI COST AND TAX RATES
ALTERNATIVE II-B ASSUMPTIONS
1985 - 2060



Source: 1985 Report of the Trustees of the OASDI Trust Funds

*(a) Midterm surpluses*

In the years between 1990 and 2025, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these surpluses will be invested in interest-bearing Federal securities, and will be redeemable to Social Security in the years in which benefit expenditures exceed payroll tax revenues—2025 through 2060. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these surplus funds, and the political and economic implications they entail.

During the period in which Social Security trust fund surpluses are accumulating, the surplus funds can be used, indirectly, to finance other Government expenditures or reduce the public debt. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essence, the assets Social Security accrues represent internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

The net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's and Social Security taxes raised and income taxes lowered in 2020, the two tax methods have vastly different distributional consequence.

Social Security is financed by a regressive payroll tax, whose regressivity is justified on the basis that the benefit structure is progressive. The key policy issue is the significance of either scenario in the larger picture of the total Federal budget. In both instances, there is an incentive to spend surplus revenues in the 1990's, and cut back on underfunded benefits after 2020.

What will happen to the surpluses Social Security lends to the general fund? These funds will enable Congress to spend money elsewhere without raising taxes or borrowing. This money could be used to fund new Federal programs, to reduce and possibly eliminate the budget deficit, or, with sufficient surpluses, to pay off the national debt. What will happen when this debt has to be repaid to Social Security? Either general revenues will have to be increased, or spending will have to be cut.

There are a number of alternative policy options for addressing the surplus/shortage problem. One choice would be simply to cut OASDI taxes in the coming decades, and encourage workers to save privately for their retirement—through tax-favored IRA's for example—and reduce future Social Security benefits for those who do so. Alternatively, Congress could choose to create a floating tax rate, which would increase or decrease in direct relation to expenditures. This method would conform to the pay-as-you-go model of financing. Another option would be to direct a portion of the surplus OASDI revenues to the Medicare (HI) trust fund, which is expected to face severe financing problems in the coming years.

### *(b) Long-term deficits*

At this time, there are neither short-term nor long-term deficits projected in the OASDI trust funds, and though there are a wide variety of issues that must be considered in the future, there is no compelling need for Congress to make major changes in Social Security in the near-term. However, it should be emphasized that Social Security is vulnerable to general economic conditions, and should they deteriorate, Congress may need to revisit the financing of the system. Furthermore, Social Security may be subject to external political pressures to change its structure, notwithstanding its financial condition.

## 2. ISSUES

### (A) SOCIAL SECURITY'S RELATION TO THE BUDGET

Since 1981, the Congress has experienced continuous pressure to limit Government spending and reduce growing Federal deficits. This pressure reached center stage in the annual congressional budget process. Because the budget process included the income and outlays of Social Security, the program became a target of many budget-cutting proposals, which usually involved some form of COLA delay or cancellation. This gave rise to a debate about the wisdom of including Social Security in the annual budget process.

At the heart of this debate lay fundamental differences of perspective regarding the relation of Social Security to other Government programs. Advocates of removal from the budget process cite several reasons in support of their position: (1) Social Security has long range goals—it aims to provide retirement income and disability insurance that all Americans can rely on for the future—that are incompatible with the short-term revenue and spending concerns of the yearly budget cycle; (2) Social Security is funded by a separate payroll tax that is credited only to the Social Security trust funds, so the effects of a shortage of revenue or an excess of spending in other areas of the budget should not be allowed to spill over into the Social Security Program; (3) Inclusion of Social Security in the budget allowed the politics involved in the budget debate to complicate and confuse policy questions regarding the future of Social Security; and (4) Confidence in the system suffers by the impression that retirement plans must be constantly adjusted in response to the changing political climate.

Those who support inclusion of Social Security in the budget process make several points: First, that the Federal budget contains many programs that fulfill long-range goals, and that Social Security should not be excepted; Second, that it is impossible to confront the Government's taxing and spending problems comprehensively without including Social Security, which accounted for roughly 15 percent of Government outlays in 1985; Third, that despite its long-range goals, Social Security, like all Government programs, is and should be controlled by the political process, which necessarily responds to the pressures of the moment.

Another aspect of the debate concerns the effect on the budget process of the expected surpluses in the Social Security trust funds. In fiscal 1986, the system is expected to take in $5 to $6 billion more in taxes than it pays in benefits. By 1990, after two scheduled payroll tax increases, the yearly surplus will amount to an expected $55 billion. Many felt that the inclusion of this large surplus in the budget would disguise the magnitude of the deficits created by the balance of the Government's taxing and spending policies, and might reduce the pressure on Congress to reduce those deficits.

### (B) DISINVESTMENT OF THE TRUST FUNDS

Confidence in the Social Security system suffered a blow, and substantial confusion was generated as a result of actions taken by the Treasury Department during the debt ceiling crisis of late 1985. In September, Treasury began to run out of cash as it approached the debt ceiling. Unable to borrow from the general public to fund the Government's operating deficit, and in order to generate cash to make benefit payments, Treasury "disinvested" or cashed in long-term securities held by the retirement [OASI] and disability [DI] trust funds. Public perception of the disinvestment was that Treasury had used trust fund assets to operate other Government programs. Many also protested the loss of interest that the funds will likely suffer when the disinvestment amounts are reinvested in long-term securities in June of 1986. Interest loss will likely result due to expected lower interest rates at that time. The impact of the problem was compounded by the revelation, in hearings before the Senate Finance Committee, that Treasury had previously disinvested funds in August of 1984, with a loss of interest and without notifying Congress of its actions.

Disinvestment of the trust funds was made possible by virtue of the relationship between assets of the trust funds and the calculation of the debt ceiling. The debt ceiling as presently calculated includes not only debt issued by Treasury to the private sector, which totalled $1,509.9 billion at the close of fiscal 1985, but also Treasury debt issued to various Federal trust funds, which totalled $317.6 billion. The principal trust funds holding Treasury debt are the Social Security Retirement, Disability, Medicare, and Medicaid funds, and the Black Lung, Highway, Airport, Military Retirement, Railroad Retirement, Civil Service Retirement, Revenue Sharing, Foreign Military Sales, and Toxic Waste Superfund trust funds.

Debt issued to trust funds is fundamentally different from debt issued to the private sector. Trust fund debt generally arises as a result of the method which Treasury uses to account for the receipt of tax revenues which are dedicated to a specific purpose. In the case of the Social Security Retirement Fund for instance, Treasury credits the fund at the beginning of each month with the estimated amount of FICA "payroll" taxes that it expects to receive during the course of the month. The credit to the fund takes the form of short-term special debt issues—a type of security which is in effect an internal Government I.O.U. from Treasury's operating cash account to the retirement fund. Although these securities do not represent debt issued to the general public, they are included in the calculation of total Government debt for purposes of the "debt ceiling"—the statutory limit on total Government borrowing. These securities are cashed in over the course of each month as the general revenue account pays out benefits. When payroll taxes exceed benefits, as they currently do, securities accumulate in the trust fund accounts. In September 1985 for instance, the Treasury received $16.2 billion in payroll taxes, but paid out only $14 billion in benefits. On June 30 of each year, the accumulated short-term securities are converted to long-term special debt issues, which also count against the debt ceiling. The balance in the trust fund thus represents the total amount by which payroll taxes have exceeded benefits paid.

The disinvestment of the Social Security trust funds in response to the debt ceiling crisis resulted from the fact that the securities held by the funds are part of the total Government debt for purposes of calculating the debt ceiling. When total debt began to approach the debt ceiling, Treasury found itself short of cash, and was unable to issue new debt to the public to raise cash. Because Social Security benefit payments must be made each month before the month's payroll taxes are received, the Treasury needed cash to back the checks issued in the first week of November. The Treasury Secretary, who is also managing trustee of the Social Security trust funds, chose to convert long-term securities held by the trust funds into bonds which could be sold to the general public. In effect, this exchanged one form of Government debt for another without exceeding the debt ceiling.

If the special debt issues held by the funds had not been included in the calculation of the debt ceiling, Treasury would not have been able to convert the trust fund's securities into cash. However, Treasury would have also been unable to make benefit payments as it ran out of cash. This does not mean that benefits would not have been paid, because, when confronted with debt crises in the past, Congress has always provided temporary debt ceiling extensions that allowed payment of benefits. The inclusion of trust fund debt in the debt ceiling merely provided Treasury with a means of delaying the inevitable debt crisis.

However, while Treasury was able to make benefit payments on time in the face of a debt crisis, its disinvestment of the funds caused immediate concern over the loss of interest on the disinvested securities. Disinvestment of the trust funds also led to confusion and lack of confidence in the future of the trust funds, leading many critics to seek assurance that it would not occur again. One suggested solution lies in removing trust fund debt from the calculation of the debt ceiling. The attractiveness of this solution is that it provides a simple means of preventing future manipulation of the trust funds without impeding Treasury's ability to conduct routine transactions and investments. It would also further the policy goal of distinguishing the Social Security taxation and benefit process from the balance of the Government's taxing and spending programs.

Furthermore, critics maintain that inclusion of trust fund balances in the debt ceiling does not serve the ostensible purposes of a limit on borrowing by the Treasury. To the extent that the debt ceiling is intended to represent the degree to which Government has financed its programs by borrowing from the private sector, the trust fund balances distort the picture—trust funds merely represent one Treasury account borrowing from another. This distortion will increase in the future because of the expected growth of the surplus in the Social Security retirement fund from the current $33.9 billion to $584 billion in 1995 and $2.67 trillion in 2005 (estimates reflect expected increases in wages, prices, and G.N.P.).

Another long-range benefit of removing trust fund balances from the debt ceiling results from the example created regarding the financing of the Government's debt to the trust fund. In the most recent crisis, Treasury was able to finance the debt to the trust fund by raising its level of borrowing from the general public without the approval of Congress because Treasury was able to convert internally held debt into external debt without affecting the debt ceiling.

## (C) ADMINISTRATIVE ISSUES IN SOCIAL SECURITY

Over time, Congress has monitored the performance of the SSA in carrying out its most basic mission—dignified, high quality service to the public. In the 1950's and 1960's, SSA was viewed as an elite agency, marked by high employee morale and excellent management. In the past 15 years, however, there has been some concern that the agency has lost its esprit de corps, and the quality of public service has declined. Factors cited as causing this decline included new agency responsibilities (for example, the creation of SSI in 1972), multiple administrative reorganization efforts, and the fact that SSA has had nine different commissioners in the last 13 years. Many claim that public confidence in the agency is at an all time low, and that the agency's traditional emphasis on public service has been sacrificed for an emphasis on efficiency.

### *(1) SSA as an Independent Agency*

In the last two decades, many have argued that SSA's administrative performance would be improved if it were established as a separate agency, independent of the Department of Health and Human Services [HHS]. Both the National Commission on Social Security, reporting in 1981, and a majority of the members of the 1983 National Commission on Social Security Reform, recommended that the Social Security Administration be established as an independent agency. Advocates of an independent agency often cite the need for continuous, consistent leadership in Social Security, which is by nature a program involving very long-term considerations. It is frequently argued that because Social Security is a program with long-term obligations, it should be shielded from short-term partisan politics and bureaucratic infighting, and that Administrative independence would enhance public confidence in the program. For that reason, some analysts have recommended that a bipartisan board manage and oversee Social Security, and was the case in the first decade of the program—1935-46.

As part of the 1983 Social Security amendments, Congress established the Congressional Panel on Social Security Organization to identify an appropriate method for removing the SSA from HHS and establishing SSA as an independent agency, with its own administrative structure and responsibilities.

The panel's final recommendations to Congress include the following:

—An independent SSA should be headed by a single Administrator, appointed by the President, with the advice and consent of the Senate, to a statutory 4-year term.

—The agency would have responsibility for the OASDI and SSI Programs.

—A permanent, bipartisan advisory board of nine members—five appointed by the President, two by the Senate, and two by the House—would oversee the program, and would make policy recommendations to the Administrator, the President, and Congress.

—The new agency would be delegated certain administrative functions currently handled by the Office of Personnel Management (OPM) and the General Services Administration (GSA) to allow for greater operational flexibility.

The panel recommended including only Social Security and SSI in a separate agency. Medicare was not included. Opponents of including Medicare in an independent SSA point out that it would be operationally advantageous to have an agency that handles case benefits only, and that incorporating Medicare which involves third-party intermediaries and a whole different set of administrative tasks, greatly complicates the mission of an independent SSA. Also, in the same sense that it is appropriate to link OASDI and SSI, it is reasonable to want to keep Medicare and Medicaid together, due to the overlap between the programs in clientele, structure, and purpose as public health care financing programs. If both Medicare and Medicaid were to be brought under SSA, it would leave HHS with little responsibility. Some argue that SSA would then be an enormously complex, multi-program agency, with all the problems attendant upon HHS at present.

The various proposals to establish SSA as an independent agency raise a number of important policy issues—most fundamentally, the question of whether it is necessary to remove SSA from HHS. Sponsors of independent agency proposals often point out that since 1971, SSA has had nine different Commissioners and HHS has had six different Secretaries. SSA has been administratively reorganized a number of times in the past decade, and there has been very little continuity or long-term coherence in leadership and policy. Further, advocates point to major policy debacles that have plagued Social Security in the past 5 years, including the crisis in the Disability Insurance (DI) program created by the overzealous implementation of the continuing disability reviews, and the retroactive elimination, and subsequent restoration of the Social Security minimum benefit. Supporters contend that with an independent agency, high level leadership would be more sensitive to the integrity of Social Security, and more effective in promoting sound policy and administration.

Opponents of an independent SSA point out that most agency problems do not result from SSA's location as a part of HHS, but are rather the result of poor planning and policymaking. Organizational structure may be less to blame than bad leadership, low morale, and the disruptive effect of ill-considered and voluminous congressional legislation. Some claim that changing an administrative structure will not by itself eliminate the problems of bad policy. This can only be accomplished by appointing intelligent and competent officials, and by Congress making legislative decisions less haphazardly and with greater consideration for the administrative ramifications of statutory changes.

Opponents of an independent agency also argue that an independent agency would not, and should not, put Social Security above politics. A board appointed by the President would not necessarily be politically neutral, nor would a single administrator. In establishing an independent tribunal, with diminished accountability to the President, it is argued that Social Security will be less accountable to the views of the public, and less subject to reform or revision should that become desirable or necessary in the future.

### *(2) Recoupment of Overpayments*

A very specific administrative concern in the recovery of benefit overpayments was revealed in a December 1983 Senate Aging Committee hearing on "Social Security: How Well Is It Serving The Public?" Many recipients of Federal benefits elect to have their payments made directly to their bank account by an automatic credit process called electronic funds tranfers [EFT]. In cases where these beneficiaries die, but continue to receive benefits, Social Security notifies the Treasury Department that too much money has been credited to the account of the beneficiary. The Treasury Department then seeks to recover payments for the month of death or thereafter by directing the bank where the beneficiary has an account to return the amount owed to the Government. At the time of the 1983 hearing, this process took place with no advance notice to the beneficiary or joint account holder. In 1983, there were over 300,000 Treasury recoupments involving the use of EFT procedures.

Because the bank was required to quickly comply with the order to return the money to the Treasury Department, any notice provided by the bank usually occurred after the recoupment. This arrangement resulted in cases in which the Treasury Department and the bank erroneously recovered overpayments from EFT accounts without affording the beneficiary or account holder a chance to contest the overpayment claim or to seek a waiver of the recovery. It caused much confusion and hardship to some Social Security beneficiaries.

At the close of the hearing, Senator Heinz asked Treasury Department officials to correct the problem by amending the Federal regulations dealing with overpayment collections from direct deposit bank accounts. In response, the Treasury Department issued new regulations, which became final on December 17, 1984.

The new regulations required that banks notify beneficiaries of actions to refund "erroneous" EFT transfers to the Treasury. The notice procedure covers recoupment of Social Security, black lung, SSI, and veterans benefits and civil service, railroad, and military retirement payments. The notice informs the beneficiary that the bank can stop the recoupment presented with evidence that the fact of death or date of death is in error. It also advises the account holder that he or she may be eligible for survivor's benefits and that the Federal agency making the payments should be contacted to determine eligibility for benefits.

Although this notice procedure may help to prevent erroneous recoupment by Treasury as a result of mistaken death reports, it does not help a surviving spouse where the death report is accurate. This is because, while surviving spouses and children may be entitled to payments in their own right, benefits paid in the name of a deceased technically do not belong to his or her survivors. SSA continues to seek recoupment of payments made to joint accounts of decedents and their survivors, despite the strong likelihood that SSA will have to make direct benefit payments to these persons in the future. Critics of this practice believe that SSA should treat these payments as mere overpayments, which would allow recipients to request waiver, reconsideration, or manageable repayment schedules.

### *(3) Closing Field Offices*

SSA currently operates 640 district offices, 677 branch offices, 75 resident stations 3,400 contact stations, and 34 teleservice centers across the Nation. Recent attempts by SSA to reduce the number of its field offices and employees has raised concerns that widespread reductions could cause a deterioration in the quality of public service.

Critics have charged that, in the 1980's, SSA shifted its focus away from the outreach efforts of the 1970's and instead focused on improving efficiency. As a result, many of the smaller and less efficient field offices opened in the 1970's to increase or improve services have become targets for downgrading or closure. Since 1981, SSA has closed 27 field offices and opened only 3, with 20 of the closings occuring in the last 2 years. Another 37 field offices have been downgraded since 1981, while only 15 have been upgraded. SSA has also closed over 600 contact stations since the end of 1982.

In 1985, congressional attention focused on staff reductions which the administration recommended as part of the fiscal year 1986 budget request. The proposed SSA staff cuts mirrored the 1983 Grace Commission report, which recommended that SSA eliminate 17,000 staff positions and also close over 800 field offices, based upon the rationale that operating a single large office in a city of 500,000 to 1 million would be cheaper than operating several small offices. Critics pointed out however, that the Grace Commission's rationale rested entirely on cost factors, and failed to assess the effect of closings on the quality of public service.

While most critics recognized that SSA needed to monitor its operating costs closely, and that some offices might have to be closed in order to provide better services, they nonetheless believed that SSA was pursuing cost cutting without regard to the quality of service being provided. Critics also pointed that SSA often did not consult with members of affected communities before closing field offices. Hearings held in Pittsburgh by the Senate Special Committee on Aging highlighted both the lack of communication between SSA and local communities, and the impact of closings on the communities.

### *(4) Computer Modernization*

Although SSA was once a leader in using automation to improve its operations, the last 10 to 15 years have seen its computer systems deteriorate to the brink of disaster. In the early 1980's, this deterioration affected virtually every aspect of SSA's operations, including its organization, management, personnel, and ability to serve the public. In the past decade SSA has made three attempts to modernize its computer operations, none of which have been completely successful. Beginning in the 1980's SSA began to implement an ambitious program to completely modernize its computer operations.

In the last 3 years, SSA made considerable progress in its systems modernization plan. In March 1985, after development of new software, SSA activated the first pilot group of two district offices using fully automated claims processing techniques with on-line data entry and query. An additional pilot group of 18 offices began processing claims in January 1986, when SSA also closed bids on contracts to supply 22,000 terminals for the rest of its district offices. SSA expected to award the bids in August 1987, and, after a test installation period, expects to begin acceptance and installation of 1,500 terminals per month in January of 1988. The new system will eliminate enormous amounts of paperwork and will allow workers in district offices to obtain instant access to the massive benefit and earning records stored at SSA headquarters in Baltimore. Once the system is installed in the district offices, SSA will proceed with modernization of the data storage system at its headquarters.

Unfortunately, SSA's progress in modernizing their operations has been marred by allegations of improprieties in the awarding of contracts to various computer companies which serve SSA. In 1984, the House Committee on Government Operations found that a major data communication contract awarded by SSA to the Paradyne Corp. had been tainted by questionable action on the part of the contractor and inappropriate conduct on the part of SSA officials. In the wake of these revelations, the Government Operations Committee recommended that SSA bar Paradyne Corp. from Federal contracts for 3 years. The SSA official was later convicted of accepting a bribe on a related software contract, and was sentenced to 4 years in prison.

Further controversy arose in 1985 when the Government Operations Committee uncovered improprieties associated with the award of the largest computer consulting contract in SSA's history—a $32 million award naming Electronic Data Systems as prime contractor, and the accounting firm of Deloitte, Haskins & Sells ["DHS"] as the major subcontractor. Hearings held on November 6, 1985, made public a GAO study which disclosed that DHS received privileged treatment in familiarizing itself with SSA operations, and in gaining access to key SSA personnel prior to bidding on the contract. The privleges included providing DHS with office space in the Commissioner's suite for 2 years prior to letting the bids, purchase of meals for SSA personnel by DHS in contravention of rules governing the contract bidding process, and inclusion of DHS personnel in administrative decisionmaking at SSA.

The Government Operations Committee expects to continue its investigation of this contract and other bidding practices and administrative mistakes which they claim have put SSA's modernization program at least 2 years behind schedule, and more than $300 million over its original $500 million budget.

### (D) BENEFIT ISSUES

Social Security has an elaborate system of determining benefit levels for the 36 million Americans who currently receive them, and for all who will receive them in the future. This benefit structure has evolved over time, with Congress mandating changes as it felt necessary. Presently, there are a number of specific issues related to the benefit structure that have drawn the attention of Congress.

### *(1) The Social Security "Notch"*

In 1985, interest in the Social Security "Notch" problem leveled off in both the media and in Congress. Concern about the "notch" became widespread in 1983 after a series of articles by a syndicated newspaper columnist. The "notch" is a difference in monthly Social Security benefits between those born in 1916, and those born in 1917 or later, resulting from a change in the Social Security benefit formula enacted in the 1977 amendments. The difference is substantial only for those in the highest benefit levels who defer retirement until age 65. This problem became noticeable as individuals born in 1917 became age 65 in 1982.

The problem stems from a series of changes the Congress made in the Social Security benefit formula, beginning over a decade ago. In 1972, the Congress enacted automatic annual indexing of both the formula to compute initial benefits at retirement, and of benefit amounts after retirement. The intent was to eliminate the need for ad hoc benefit increases, and to fix benefit levels in relation to economy. However, the method of indexing the formula had a flaw in it in that initial benefit levels were being indexed twice—for increases in both prices and wages. Consequently, initial benefit levels were rising rapidly in relation to the pre-retirement income of beneficiaries. Before the 1972 amendments took effect, Social Security replaced 38 percent of pre-retirement income for an average worker retiring at age 65. The error in the 1972 amendments caused replacement rates for the average worker retiring at age 65 to rise as high as 55 percent for the cohort born in 1916.

Without a change in the law, the average worker retiring around the turn of the century would have been receiving more in monthly Social Security benefits than he was earning prior to retirement. This projected growth in relative benefits was the cause of the long-run deficit estimated in 1977 at 8.2 percent of taxable payroll. Had the Congress elected to finance this increase rather than reduce benefits, it would have had to double the Social Security tax rate. Instead, in the 1977 amendments the Congress chose to recoup part of the increase in relative benefits and finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of pre-retirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately, high rates of inflation in the late seventies and early eighties made the difference in monthly benefit levels between the cohorts born before and after 1917 greater than intended. The difference became most extreme for those who deferred retirement, particularly those with maximum earnings. For two maximum earners with identical earnings histories, one born in 1916 and the other in 1917, the difference in benefits for retirement at age 62 was only $7 a month. However, these same individuals retiring at age 65 received benefits differing by $111 a month.

Although the notch is actually the result of an over-indexation of benefits for those retiring under the old formula, and does not reflect any reduction in real benefits to those retiring under transition rules, it has been perceived as a benefit reduction by those affected. Individual Members of Congress have responded to the complaints of this group by introducing a series of proposals for relief, most of which would give benefit increases to notch-year retirees at a high cost to Social Security.

### *(2) Earnings Sharing*

Social Security currently provides benefits to women in one of two ways—either as a covered worker in her own right based upon her own earnings record or as a dependent wife, widow, or ex-wife of a covered workers. However, a woman cannot receive both benefits. Therefore, in the case of a one-earner couple, the Social Security benefit provided to a married couple is equal to one and one-half times the benefit earned by the employed spouse. In the case of a two-earner couple, the Social Security benefit is based technically on their combined earnings record, but the lower earner's record is subsumed into the dependent spouse benefit, unless and until that record provides a larger benefit than the dependent spouse benefit.

This benefit structure was designed when less than 17 percent of married women worked outside of the home and the predominant family pattern was single-earner couples where the woman was the full-time homemaker and marriages were life long. Since mid-century, however, very different social patterns have emerged. The number of two-earner couples for example, has risen dramatically, as has the number of marriages ending in divorce. Indeed, many of the presumptions upon which the Social Security system was built have changed.

Three distinct groups of women may be considered disadvantaged by the current Social Security system. First, widows whose husbands die early have often been the recipients of reduced benefits for either of two reasons: (1) Their husband's incomplete earnings records yield low benefits; and (2) widows often take actuarially reduced benefits at younger ages.

Second, divorcees are entitled to dependent's benefits based on their last marriage—of 10 or more years duration—and are disadvantaged in two respects. The working ex-spouse may decide to retire early, without consulting his ex-wife and her benefits as a dependent spouse will be reduced. More importantly, if the marriage does not last 10 years, a divorcee is not entitled to a dependent spouse benefit at all. Where women's work histories have been interrupted by unsuccessful marriages, an insubstantial earnings record and inadequate benefits are the inevitable result.

Finally, two-earner couples are disadvantaged by the current formula for determining benefits. A two-earner couple whose combined earnings equal those of a one-earner couple receive benefits substantially less than the one-earner couple. This is due, in part, to the additional dependent-spouse benefit the one-earner couple receives. It also results from the fact that the base salary for determining the benefit of the two-earner couple will be the higher earner's salary, unless the lower earner is entitled on the basis of a separate earnings record to a larger benefit than the lower earner would be entitled to as a dependent of the higher earner.

The earnings sharing proposal has emerged as the most popular of several comprehensive plans that would address these equity and adequacy issues. Under earnings sharing, a couple's annual aggregate earnings would be divided equally between them for the purposes of computing a Social Security earnings record. This would effect three principle goals:

First, the individual would be entitled to a Social Security benefit in his or her own right, thus removing any stigma of dependency attached to that benefit. Some argue that the change would merely recognize the value of a woman's work in the home.

Second, it would allow divorced and widowed spouses to build on the earnings records amassed by their former spouses to improve their Social Security benefits.

Third, it would remedy the present inequities between one- and two-earner couples whose identical aggregate income yields unequal Social Security benefits.

Although no earnings sharing bill received serious consideration in 1985, this proposal has nonetheless been a subject of much discussion. The Social Security amendments of 1983 required that the Social Security Administration study the costs and the benefits of the earnings sharing proposal. That study, due in July, was delayed until December so that analysts could complete a study of three alternative models of earnings sharing. The three models studied were:

First, a no-loser proposal: Earnings sharing would be used to figure a participant's benefits, only if it afforded higher benefits than current law.

Second, strict earnings sharing: Benefits would be figured under earnings sharing as of a specified date regardless of the impact on the individual participant.

Third, moderated earnings sharing: The percentage of current law benefits guaranteed against earnings sharing would be gradually reduced over a period of 40 years when all participants' benefits would be figured by earnings sharing.

While earnings sharing would remedy the current inequities between one-earner and two-earner couples, preliminary analyses suggest that it is far less effective at improving the adequacy of benefits received by older widowed and divorced women. Since Social Security currently provides a spousal benefit to a divorced spouse after 10 years of marriage—so long as she does not remarry—Social Security benefits based only on the income earned during the marriage might be significantly lower, comparatively. Earnings sharing itself does nothing to remedy the problems of widows benefits under Social Security, except to encourage younger widows to add to the work record amassed by their spouses. To the extent that they do not, they will continue to receive inadequate benefits. While some earnings sharing proposals address this problem by guaranteeing at least current law benefits—the so-called no-loser bills—this adds tremendously to the implementation costs of earnings sharing. Other proposals include a measure allowing inheritance of Social Security credits upon the death of a spouse, which would increase benefits for individuals living alone in old age.

It is likely that earnings sharing will receive more attention in 1986. However, policy concerns such as the implementation costs, adequacy of benefits to divorced and widowed elderly, as well as the political impracticality of modifying with Social Security so soon after the 1983 amendments will most likely retard the progress of the legislation.

## 3. Legislation

For nearly a decade prior to 1983, Social Security occupied the attention of Congress primarily due to the threatened insolvency of the system. In 1983, legislation was passed that restored the financial health of the system's trust funds. With the decline of the insolvency problem, Social Security declined in urgency as an issue, although it continued to occupy the attention of Congress.

### (A) FISCAL YEAR 1986 BUDGET RESOLUTION

In 1985, as Congress attempted to thrash out measures to reduce the large Federal budget deficits projected for fiscal year 1986 and later years, a number of proposals were considered to limit future Social Security cost-of-living adjustments (COLA's).

Measures to reduce Social Security COLA's were first given serious consideration when the Senate Budget Committee proposed that the January 1986 Social Security COLA be skipped. COLA constraints affecting other Federal benefit programs, among them civil service and military retirement, had been proposed by the President in his fiscal year 1986 budget submitted in January 1985; however, Social Security had been exempted. The measure was included in S. Con. Res. 32, the committee's proposed first concurrent budget resolution for fiscal year 1986.

An alternative COLA cutback proposal emerged shortly thereafter, as part of a substitute deficit-reduction package developed jointly by the administration and the Senate Republican leadership. Instead of freezing COLA's in the affected Federal programs for 1 year, it would have limited the COLA's for the next 3 years to 2 percent per year plus any amount by which inflation exceeded the administration's assumptions (its assumptions at that time suggested that inflation would hover in the high 3 or low 4 percent range during the next few years). It further included a guarantee provision under which the affected COLA's could not be less than 2 percent.

Initially, when the Senate took up the Budget Committee's proposed first budget resolution, it rejected both the COLA freeze and the alternative COLA limitation by agreeing on May 1, 1985 (by a vote of 65 to 34) to an amendment by Senator Dole, for Senators Hawkins and D'Amato, to provide for full funding of Social Security COLA's. However, on May 10, 1985—after considering many amendments to the Budget Committee's recommendation—the Senate adopted (by a vote of 50 to 49) an entirely revised budget package, introduced by Senator Dole, which incorporated the original COLA freeze recommended by the committee. Subsequently, the Senate considered an amendment by Senator Moynihan to provide a full Social Security COLA in January 1986, but it was tabled (by a vote of 51 to 47). The final budget resolution then passed by the Senate assumed later enactment of the 1986 COLA freezes, including one affecting Social Security.

The House-passed version of the first budget resolution for fiscal year 1986, H. Con. Res. 152, assumed that full COLA's would be paid in all Federal benefit programs in fiscal year 1986. During floor debate on the resolution, the House rejected two amendments to limit Social Security COLA's.

Conferees for the House and Senate met throughout June and July 1985 to work out an agreement on a deficit-reduction package. Among a number of ideas that surfaced were proposals to: Delay the Senate-passed COLA freezes until 1987, means test the COLA's, make both the COLA's and adjustments to income tax brackets effective every other year (instead of annually), and increase the amount of Social Security benefits that would be subject to income taxes. Ultimately, however, agreement could not be reached on any form of Social Security restraint, and the conference agreement on the First Concurrrent Resolution for Fiscal Year 1986, passed on August 1, 1985, did not assume any such savings.

### (B) GRAMM-RUDMAN-HOLLINGS

In response to attempts to include any Social Security changes in the deficit-reduction package, a number of measures emerged in the fall of 1985 to remove Social Security from future Federal budgets and make it procedurally difficult for Social Security cutback measures to be brought up in the congressional budget process. Senator Heinz brought an amendment to S. 1200 (the Immigration Reform and Control Act of 1985) supporting removal of Social Security from the budget. This led the Senate to agree to an amendment instructing the Senate Budget Committee to report back legislation intended to assure that Social Security benefit changes would not be made for deficit-reduction purposes beginning in fiscal year 1986, and to change the congressional budget process to make it "ineffective to seek to achieve deficit reductions through changes in Social Security benefits."

Further steps to keep budgetary actions from affecting Social Security were taken the following month, when the Senate passed H.J. Res. 372, which raised the statutory debt ceiling and adopted the Gramm-Rudman-Hollings budget balancing procedures. Although early draft versions of the budget balancing measure would have required the President to curtail Social Security COLA's if the deficit targets (specified in the legislation) were expected to be exceeded, the actual amendment introduced on October 3, 1985, by Senator Dole (and Senators Gramm, Rudman, Hollings, et al.) exempted Social Security from any expenditure reductions resulting from the procedures. An amendment offered by Senator Boren on October 10, 1985, would have included Social Security COLA's among those that would be subject to automatic reduction, but it was rejected (by a vote of 71 to 27). Under the bill, as finally passed by the Senate on October 10, 1985, Social Security's income and outgo would be counted from fiscal year 1986 through fiscal year 1991 in assessing whether and the extent to which the Government was achieving the required deficit-reduction goals, but the program would be exempt from any cutbacks the President might have to make. The measure also made it "out of order" for a budget resolution or reconciliation bill brought up in the House or Senate to include changes to Social Security. It further stipulated that Social Security would be considered off-budget immediately upon enactment (instead of beginning in fiscal year 1993, as provided by the Social Security amendments of 1983).

The House took up and passed (by a vote of 249 to 180) its own budget balancing measure on November 1, 1985, through an amendment offered by Representative Rostenkowski to the Senate-passed bill, which called for budgetary treatment and exemptions for Social Security similar to those specified under the Senate bill.

An agreement on H.J. Res. 372 was ultimately reached by the conferees on December 10, 1985, retaining the special budgetary treatment of Social Security benefits reflected in the House and Senate bills. The final measure, however, did include Social Security administrative expenses within the sphere of Federal administrative expenses that would be subject to potential cuts, and made further procedural and technical changes in the way Social Security would be handled in the budget process. President Reagan signed H.J. Res. 372 into law on December 12, 1985, as Public Law 99-177—The Balanced Budget and Emergency Deficit Control Act of 1985.

The second provision concerning Social Security restored to the trust funds the amounts disinvested by the Treasury during the debt ceiling crisis. Congress also ordered Treasury to completely repay any interest which the trust funds lost due to the disinvestment in 1985, and also any interest which was lost due to similar maneuvers in 1984.

Gramm-Rudman-Hollings was also significant because of its lack of direct impact on Social Security, which was specifically exempted from the automatic budget cuts that will take place between 1986 and 1991 if the Government fails to meet its deficit-reduction targets. However, while Social Security benefits and COLA's are protected, the program may nonetheless suffer from cuts in SSA's administrative budget, which is not exempt from Gramm-Rudman-Hollings.

### (C) SOCIAL SECURITY TECHNICAL AMENDMENTS

Other legislation concerning Social Security was included in the omnibus reconciliation bill for 1985. Passage of the bill stalled in the final moments of the 1985 session, but Congress was expected to resume consideration of the bill in 1986. The most significant of several "technical" amendments to Social Security was a provision regarding recoupment of overpayments to spouses and survivors of deceased recipients of benefits. It required that, where electronic fund transfers are made into joint accounts of decedents and their survivors, and the survivor is entitled to SSI benefits or to Social Security benefits based on the earnings record of the decedent, the overpayment is not automatically recovered by the Treasury from the joint account. Instead, the survivor will have the right to seek waiver, reconsideration, or gradual repayment of the overpayment.

### 4. PROGNOSIS

Several factors indicate that the Social Security system faces a stable future, which will be largely free of the major policy issues that have confronted it in recent years. The 1983 changes in Social Security financing have for the most part guaranteed the solvency of the system and reduced the pressure on Congress to legislate changes in the program to improve its financing. The removal of Social Security from the unified budget will also provide some insulation from program cuts. In addition, the Gramm-Rudman-Hollings Act specifically excludes Social Security from the effect of automatic spending cuts.

However, the drastic nature of the cuts mandated by the Gramm-Rudman-Hollings Act also indicates the degree to which Congress is concerned about the growth of the Federal deficit, and this concern may eventually affect Social Security. Tax increases might eliminate some of the deficit, but, even with tax increases, tremendous pressure will remain on all spending programs. It is possible that, in an attempt to stave off the mandatory cuts of Gramm-Rudman-Hollings, Congress might voluntarily delay or cancel Social Security COLA's. Congress might also increase the taxation of Social Security benefits, or alter the formulas used to calculate benefits for future recipients.

## B. SOCIAL SECURITY—DISABILITY INSURANCE

### 1. BACKGROUND

In 1985, SSA settled down to the business of implementing the provisions of the Social Security Disability Reform Act of 1984. This legislation revises the standards and the process used by the SSA in reviewing the eligibility status of beneficiaries on its rolls. Periodic reviews of DI beneficiaries began as a result of the 1980 DI amendments. Under these amendments, SSA reviews beneficiaries at least once every 3 years, except those designated permanently disabled, who are reviewed once every 6 or 7 years. These periodic reviews are designed to remove from the rolls those beneficiaries who are no longer disabled, or never were disabled, and should not be receiving benefits.

Between March 1981 and April 1984, about 1.2 million case reviews were completed, and just under 500,000 beneficiaries were determined no longer eligible for DI benefits. In other words, 45 percent of those subject to a continuing disability investigation [CDI] were terminated from the DI rolls. This high termination rate, in conjunction with the fact that two-thirds of those who appealed to an administrative law judge [ALJ] had their benefits reinstated, led to concern that the CDI's were being administered in an improper and unjust manner.

Specifically, critics charged that the CDI's were being conducted hastily and haphazardly, and that the review simply did not render accurate or valid conclusions about a beneficiary's capacity to work. Though the problems with the disability review process are very complex and multifacted, controversy centered on four key issues: (1) The extent to which persons can be terminated whose disabling condition has not improved, or even worsened, since their admittance to the rolls; (2) the manner in which medical evidence is obtained and evaluated; (3) the great discrepancy in standards of evaluation between State disability examiners, who initially conduct the CDI's and ALJ's; and, (4) the degree to which the mentally disabled have been discriminated against by the CDI's.

The various problems with the continuing reviews were the focus of the congressional hearings held by the House Ways and Means Committee, the House Select Committee on Aging, the Senate Committee on Finance, and the Senate Special Committee on Aging. Legislatively, the House and Senate passed differing versions of H.R. 3755 in the spring of 1984. By September, House and Senate conferees had negotiated an agreement, and final legislation was signed by the President on October 10, 1984 [Public Law 98-460].

Prior to congressional action, many States, on their own initiative or by court order, declared moratoria on the reviews, or began administering the CDI's under guidelines that differed from SSA's official policy. At the beginning of the year, more than half the States were either not processing CDI's, or were doing so under modified standards. This unprecedented rejection of Federal policy is indicative of the magnitude of the crisis in the DI program created by the CDI's.

## 2. Issues

### (A) GROWTH AND CONTRACTION IN THE DI PROGRAM

Virtually all the complicated and esoteric aspects of the controversy in the DI Program boil down to one central question; how stringent or lenient do we want to be in the application of the DI Program? In Congress some argue that the DI Program is a runaway social welfare program, one that has grown far beyond the intentions of Congress, and that SSA's efforts to eliminate large numbers of people from the DI roles is justified. Critics of the CDI's in Congress claim that SSA was overzealous in administering the program, and that people who were clearly unable to work were being unfairly kicked off the rolls. Though the actual debate is very complicated, it centers around one group calling for a very stringently administered program versus another group arguing for more lenient operation.

The broad definition of disability coupled with the difficulty involved in making objective determinations of disability, has made the DI program highly volatile, causing it to expand and contract in response to changes in administrative priorities, and in response to the overall climate in which case-by-case adjudication occurs.

### *(1) The Definition of Disability*

When Congress created the DI Program in 1954, the definition it chose for "disability" was very strict. It was feared that anything other than a very restrictive definition would lead first, to high costs, and second, to confusion between disability—inability to perform work—and unemployment—inability to find work. The original definition required that to be eligible one had to be over age 50, insured under Social Security, and incapable of engaging in any work by reason of a medical impairment which was expected to be permanent.

Over time the definition has been modified. In 1958, the coverage requirements were liberalized and dependents' benefits were made available. In 1960, the age 50 requirement was dropped. In 1965, the permanent disability standard was replaced by a more lenient definition: The disabling impairment only had to be expected to last at least 12 months or end in death. This brought under the program those who might recover and return to work, as well as those who were expected to remain disabled until death. In 1967, Congress tightened the definition of disability in response to Federal court decisions requiring SSA to demonstrate that a denied applicant could reasonably expect to find employment in his region of the country.

Since 1967, the basic definition of disability has remained essentially the same. An individual is not considered disabled unless his physical and mental impairments are of such severity that he is not only unable to perform in his previous occupation but cannot, considering his age, education, and work experience, engage in any kind of employment which exists in the national economy, regardless of whether such work exists in the region in which he lives, or whether a specific vacancy exists for him, or whether he would be hired if he applied. This is a very stringent definition, one that is meant to screen out those who cannot work because of a medically determinable impairment and those who cannot work for other reasons, such as obsolete skills, poor motivation, or job scarcity.

Though forceful as general concept, this definition provides little specificity in determining disability in individual cases. To translate the broad statutory mandate into a workable administrative system, SSA has over the years developed an elaborate and immensely complicated scheme of regulations and rules to determine disability on a case-by-case basis. At the center of this sytem are a set of lists—the "listings of impairments"—of specific, medically identifiable impairments whose existence alone warrants a determination of disability. The listings are a way of coding a large group of very severe medical conditions that are considered, by definition, disabling. This sytem allows a disability examiner to match a doctor's report against a set of uniform criteria, and make a clear-cut decision either way.

If an individual's impairment(s) does not "meet or equal" the listings, his "residual functional capacity" is assessed to determine whether he is nonetheless disabled. Unlike the listings, which are based on medical criteria, the evaluation of residual functional capacity is based on vocational factors. To accomplish this task, SSA has a complex "grid" system in which basic work skills are matched with such factors as age, level of education, and vocational experience to determine whether an individual can actually work. Vocational factors are given highest priority for applicants over the age of 55.

The very concrete and specific rules that underpin this two-stage evaluation process are spelled out in Federal regulations, and equally important, in the program operations manual system [POMS], an enormous body of internal administrative instructions and guidelines. The POMS are written by SSA, and sent to State disability determination service [DDS] agencies, which make the actual disability determinations under contract with SSA. The POMS and regulations are enforced through regional and national reviews of selected cases, and through clarifying internal memoranda. Overall, this elaborate system is structured to ensure to the greatest extent possible national uniformity and objectivity in determining disability.

Though objective in design, the disability determination process remains highly subjective. Two doctor's can examine the same individual and reach different conclusions. Two disability examiners can read through the same medical evidence in a file and make differing decisions. Two individuals may have identical impairments, but respond to them in radically different ways. There are a number of areas where medical taxonomy and understanding is weak or where an impairment is identified through indirect evidence. There are areas in which it is difficult to sort out the extent to which the individual is or is not responsible for the problem. Multiple impairments are very hard to consider in combination. Non-Medical factors are even more ambiguous. On the margins, which are very wide, the question arises, do you or do you not give the applicants the benefit of the doubt? In periods of program expansion, the answer tends toward yes, in contraction, no.

### *(2) The Disability Incidence Rate*

Over time, one key indicator of the generosity or stringency of the DI Program is the "disability incidence rate," a measure of the number of workers awarded DI benefits in any year as a fraction of the total number of workers insured for DI benefits. Throughout the 1960's, the disability incidence rate was fairly constant, particularly when legislative changes are taken into account. However, beginning in 1970, the disability incidence rate increased by almost 10 percent a year until 1975 when it reached its peak. After 1975, the rate started to decline. This decline became precipitous following 1979. It dropped to an historic low in 1982, during the period of most intensive retrenchment. Social Security actuaries currently project that the disability incidence rate will remain low, though ascending modestly for the next decade.

#### *(a) The expansionary period*

Growth in the early and middle 1970's had an enormous effect on the size and cost of the DI Program. Between 1970 and 1976, the number of disabled workers almost doubled, while the covered work force increased by only 25 percent. In 1970, annual expenditures under the DI Program were $3.3 billion; in 1980, they amounted to $15.9 billion.

A number of factors are usually cited in describing the expansion of the DI Program. First and foremost is lenient Federal management. The Black Lung program and the Supplemental Security Income [SSI] program went into effect in the early 1970's, and added substantially to SSA's administrative burden at a time when DI applications were rising rapidly. To process these claims, SSA established a number of expedients in the area of development, documentation, and review of claims. For instance, SSA eliminated its 100 percent review of State DDS cases and instead only sampled a small percentage of decisions. The net result of this pressure to process claims may have been a tendency to give the applicant the benefit of the doubt in "gray area" cases.

Another important factor was the social acceptance of disability. Though medical evidence points to no increase in impairments, workers of all ages in the 1970's increasingly claimed that they were disabled. This was compounded by greater public awareness of the availability of benefits, by the creation of SSI, by higher Social Security benefit levels due to across-the-board Social Security increases mandated by Congress, and by high unemployment.

### *(b) Program contraction*

Beginning in 1978, a major contraction in the DI Program began. The disability incidence rate was halved between 1977 and 1982. Despite inflation, DI benefit costs have remained fairly constant between 1981 and 1984, hovering at about $17 billion. The total number of DI beneficiaries has decreased from an historic high of 4.9 million in 1978 to 3.8 million in 1984.

The most significant factor affecting the decline was a change in the "adjudicative climate" in the DI program. Prodded by criticism by GAO and Congress, SSA made a number of administrative changes to make the eligibility and review process more strict. SSA began reviewing more State agency cases, and returning them to clarify SSA's interpretation of the law. SSA began to crackdown on interstate variation in eligibility standards, and implemented a number of regulatory and administrative procedures to assure more centralized control over the program. Overall, disciplinary pressures were created to minimize the flexibility of State agency examiners in "gray area" cases. Administrative standards were promulgated that reflected a strict, conservative interpretation of the law.

Legislation enacted in the late 1970's also had an effect. In 1977, Congress substantially increased payroll taxes, and revised the method of indexing benefits. This legislation decreased future benefits, and may have made DI less financially attractive to potential applicants.

The Social Security Disability Amendments of 1980 were broader in scope, and are the explicit source of the current controversy in the DI Program. The 1980 amendments had been developing since 1974, and were a product of concern that work disincentives, in combination with loose administration and large benefits, were responsible for the growth in the program. The 1980 amendments required SSA to more systematically review State agency performance, as well as that of ALJ's, who are often cited as a liberalizing element in the disability determination system. The legislation put a limit on maximum family benefits to ensure that beneficiaries would not receive benefits in excess of pre-disability earnings. It also included a number of provisions to lessen work disincentive in the program.

The provision in the package that has had the biggest impact on the program is the requirement that SSA review the continuing eligibility of beneficiaries, except for those permanently disabled, at least once every 3 years.

### (B) THE CONTINUING DISABILITY INVESTIGATIONS [CDI'S]

Since the inception of the DI Program, SSA had the responsibility of continuously monitoring the eligibility of beneficiaries on the rolls. In response to the concern that SSA was not reviewing eligibility carefully enough, Congress included in the 1980 amendments a provision that SSA review eligibility at least once every 3 years. It should be noted that this periodic review provision was not expected to yield significant savings until 1984. The CDI's were intended to begin on January 1, 1982, with their implementation producing a net savings of only $10 billion in the 4-year period between 1982 and 1985.

A GAO report issued in January 1981 estimated that as many as 20 percent, or 584,000, of the beneficiaries on the DI rolls were either ineligible or receiving too large a benefit payment. The report claimed that SSA's management of the DI Program was deficient, and in particular that SSA's procedures for reviewing the disability status of individuals who were likely to have improved were seriously flawed. Most individuals never had their eligibility reviewed, and of those that met the criteria for reexamination, most were never actually re-reviewed. GAO recommended that SSA make more strict the administration of the program, and expedite the CDI's.

On its own initiative, SSA accelerated the implementation of the reviews scheduled to begin January 1, 1982, to March 1981. SSA witnesses at congressional hearings repeatedly cited the GAO report, and congressional pressure, as examplified by the 1980 amendments, as justification for this acceleration. However, this decision was strongly influenced, if not determined, by Office of Management and Budget directives to produce additional savings in the DI program.

The accelerated reviews were included as part of the Reagan administration's fiscal year 1982 budget initiatives, and involved reviewing 30,000 additional DI cases monthly beyond the regular review workload. In fiscal year 1980, SSA reviewed the continuing eligibility of 160,000 beneficiaries; in fiscal year 1981, close to 260,000 CDI's were conducted. Once initiated, the volume of the CDI's increased dramatically. Overall, between March 1981 and April 1984, 1.2 million case reviews were completed, and 485,000 beneficiaries were determined no longer eligible for DI benefits.

Not long after the CDI's were implemented in March 1981, congressional concern arose about the quality, accuracy, and fairness of the reviews. Press accounts of severely disabled individuals who had been terminated from the rolls began to proliferate; and constituent reports to Members of Congress began to establish an alarming pattern of questionable terminations. It became clear that close to half of all DI beneficiaries subjected to a CDI were terminated at the initial decision level, often without much warning, and in many instances without much evidence that the individual was not disabled. Significantly, about two-thirds of those terminated had their benefits reinstated, if they appealed to an ALJ.

Overall, congressional interest in the controversy associated with the CDI's has centered on a few key issues, discussed below.

### (1) Medical Improvement

One of the first problems cited with the CDI's was the fact that beneficiaries were being terminated from the rolls despite the fact that their disabling condition had not improved, or had worsened. In essence, beneficiaries admitted to the rolls under one set of standards were being reevaluated upon a new, more stringent set of standards, and many were being terminated. People who had been placed on the DI rolls 5, 10, and 15 years before the CDI's, many of whom had been led to believe they had been granted a lifetime disability pension, were removed from the rolls with little advance warning or explanation.

The central issue in the debate surrounding the concept of medical improvement is the question of who must bear the burden of proof in the determination of continuing eligibility for DI benefits. Under SSA's interpretation of the law, it was the obligation of the beneficiary to prove during the course of a CDI that his or her disability meets contemporary eligibility criteria. How long that person had been on the rolls, or whether or not that person was physically or mentally more fit for employment than when first granted disability status, was immaterial. SSA is obligated only to evaluate cases in relation to present day medical and vocational standards.

A medical improvement standard shifts the burden of proof from the beneficiary to SSA, and it becomes the obligation of the agency to demonstrate that the individual's disabling condition has improved.

Medical improvement has proven to be a very important issue in the courts. A number of Federal courts ruled that SSA's policy of only evaluating one's condition in relation to current administrative standards violated the law, and that SSA must demonstrate that an individual has improved medically while on the rolls, or that the original decision was clearly erroneous before terminating benefits. Other courts have ruled that once a person has been found disabled, there is a presumption that the individual remains disabled and that SSA bears the burden of proof in determining that beneficiary is no longer disabled.

The Ninth Circuit Court of Appeals has ruled in two cases *Finnegan* v. *Mathews* and *Patti* v. *Schweicker* that SSA must incorporate a medical improvement standard into its administration of the CDI's. Courts in virtually every other circuit have since rendered medical improvement decisions unfavorable to SSA.

### (2) Uniform Standards

One of the critical problems in the disability review process is that different levels of review are bound to different evaluational criteria. The fact that ALJ's reverse almost two-thirds of all appeals of state agency termination decisions is the most striking indication of this structural situation.

This lack of administrative uniformity has been exacerbated in the past few years through SSA's policy issuing substantive policy changes through subregulatory means, such as the POMS' internal memoranda, and Social Security rulings. These changes are not open to public comment and review. To the extent that there are ambiguities or substantive conflicts between these subregulatory standards and published Federal regulations, State disability examiners are bound to SSA administrative directives, while ALJ's adjudicate on the basis of formal regulations.

The root of this inconsistency lies in the statutory exclusion of SSA from the rulemaking requirements defined in the Administrative Procedures Act [APA] of 1946. The APA requires that if an agency intends to propose rulemaking changes, it must publish those proposals in the Federal Register and allow for public comment and review. Agencies are allowed to use internal subregulatory channels to disseminate instructions that serve to clarify or provide interpretive assistance in the concrete administration of guidelines, SSA nonetheless continues to promulgate substantive policy changes through subregulatory methods without ever allowing for public inspection.

The upshot of this practice is that there is no uniformity throughout the disability review and appeals process. State examiners are bound to a very strict interpretation of the law, and are very sensitive to SSA's internal administrative pressure and discipline. ALJ's, on the other hand, have more flexibility and independence in interpreting Federal regulations. Because of this freedom, ALJ's have acted as a brake on administrative retrenchment.

### *(3) Mental Impairments*

One of the most heavily criticized aspects of the CDI's is that the reviews have been especially harsh for mentally disabled beneficiaries. Evidence presented at a Senate Special Committee on Aging hearing in April 1983 demonstrated that the mentally impaired were among the most likely to be reviewed, and the most likely to be terminated, of the beneficiary population.

The determination of disability for the mentally impaired has proven to be particularly susceptible to swings in the adjudicative climate, due to the inherent difficulty of medically documenting mental disorders. Many mental impairments are diagnosed through indirect, symptomological evidence, and it is often hard to establish through scientific methods the precise nature and degree of the disorder. Further, the disability determination system is very much oriented toward drawing a sharp distinction between voluntary and involuntary sources of disability, so that only those who are afflicted by a catastrophic medical condition are awarded benefits, and those who simply may not want to work are excluded from benefits. With mental impairments, it is not always easy to determine whether one is or is not responsible for the problems, or whether one can or cannot control them.

In the early and mid-1970's, large numbers of mentally impaired people were put on the rolls, particularly through SSI. Following the deinstitutionalization of hundreds of thousands of the mentally ill from State hospitals, SSI and DI became major sources of support. With a favorable period of administrative leniency, the benefit of the doubt was frequently given to the mentally impaired, and thousands became entitled to benefits.

When the CDI's began, the mentally disabled were among the hardest hit. At the Senate Aging Committee hearing, GAO reported that although only 11 percent of those on the DI rolls are there because of mental impairments, 27 percent of those terminated by the CDI's were of the mentally disabled category. Further, ALJ reversal rates for mental disability appeals cases were much higher—91 percent—proportionally than for the rest of the disabled population.

In a period of contraction, those with mental impairments were particularly vulnerable. SSA sent a message to the State agencies to rigidly enforce the listing for mental impairments, which are very strict, and antiquated in the view of critics, and to be very narrow in evaluating residual functional capacity. With this tightening of standards, and with the administrative constraints caused by the sheer volume of reviews, State agencies were pressured to disentitle tens of thousands of mentally impaired beneficiaries.

In two important class action suits, *Mental Health Association of Minnesota* v. *Schweiker* and *City of New York* v. *Heckler*, SSA has been found guilty of implementing a covert and illegal policy that systematically discriminated against the mentally ill. Both courts ruled SSA must reopen the cases of all mentally impaired individuals initially denied or terminated from the disability rolls, and reexamine their eligibility under lawful guidelines.

The essence of this illegal policy consisted of SSA internal memoranda, returns and reviews to State disability determination offices requiring that if an individual does not meet or equal the listing of impairments, that person can be presumed to be capable of performing unskilled work. That policy resulted in a virtual automatic denial of benefits to mentally impaired claimants under age 50.

In New York, District Judge Jack B. Weinstein wrote that "the result of SSA's surreptitious undermining of the law was particularly tragic in the instant cases because of its devastating effects on thousands of mentally ill persons whose very disability prevented them from effectively confronting the system." He also noted that by denying disability benefits to the mentally impaired, SSA simply transferred the costs of their care to the social service agencies, hospitals, and shelters of New York City and New York State.

Both courts found that SSA was not conducting the fourth step of the sequential evaluation—the evaluation of residual functional capacity—in accordance with the law. "The assessment of RFC, if it was done at all was reduced to a paper charade in which any individual who did not meet or equal the listings was assumed, ipso facto, to be capable of unskilled work." Judge Weinstein summarized the implications of this policy in the following passage:

> The Social Security Act and its regulations require the Secretary to make a realistic, individual assessment of each claimant's ability to engage in substantial gainful activity. The class plaintiffs did not receive that assessment. On the contrary, SSA relied on bureaucratic instructions rather than individual assessments and overruled the medical opinions of its own consulting physicians that many of those whose claims they were instructed to deny could not in fact work. Physicians were pressured to reach conclusions contrary to their own professional beliefs in cases where they felt, at the very least, that additional evidence needed to be gathered in the form of a realistic work assessment. The resulting supremacy of bureaucracy over professional medical judgments and the flaunting of published, objective standards is contrary to the spirit and letter of the Social Security Act.

### *(4) Quality of the CDI's*

Not long after the CDI's were first implemented, it became clear that there were serious inadequacies in the review process. Without sufficient time, staffing, or resources, State agencies were forced to process far too many CDI's, far too quickly. Further, the manner in which the cases were developed, including the collection of medical evidence, came into serious question.

The simple increase in volume from a routine 160,000 reviews per year to roughly 500,000 CDI's in fiscal year 1983, in and of itself accounts for a major dimension of this problem. The phase-in period was much more rapid than intended by Congress, and State agencies sacrificed thoroughness and accuracy for speed and efficiency. As in the mid-1970's, case examiners found themselves under severe pressure to process claims quickly. In this instance, however, the signal from SSA was to deny claims whenever possible.

Another problem cited with the CDI's was their impersonal, paper-oriented character. CDI's were conducted without the benefit of any face-to-face interaction between the beneficiary and the disability examiners. Before the ALJ stage, determinations were based strictly on written evidence. Further, beneficiaries were often provided with little information as to what a CDI entails, what was expected to them, and what the range of potential outcomes from the CDI might be.

### *(5) Multiple Impairments*

Another issue of interest to Congress is the role that the combined effect of multiple impairments should play in the disability determination process. Under SSA's administrative practice, if an individual had several impairments, none of which on their own constitute a severe impairment, that individual was disqualified at the first level in the sequential evaluation, the test of a severe or nonsevere impairment. There was no determination of whether vocational factors might be disabling, or whether nonsevere impairments might cumulatively render an individual unable to work.

SSA reasoned that if an impairment does not substantially limit an individual's ability to work, the individual was not disabled, and there was no point in continuing the sequential evaluation. Further, it was assumed that a combination of nonsevere impairments would not seriously restrict ability to work. In view of the structure of the eligibility determination process, SSA categorically denied eligibility when the first test of disability—is there a severe impairment?—failed. In the past few years, rejection of claims on the basis of not having a severe impairment increased dramatically, and closing this point of entry into the review system has led to many denials.

Critics argued that SSA was violating the meaning of the law in denying a claimant a realistic, individualized assessment of work ability by not evaluating impairments in combination and not examining vocational factors. SSA's categories served to exclude people who, if evaluated in totality, were disabled. Like mental impairments, the combined effects of multiple impairment are difficult to identify medically, and involve what is ultimately subjective judgment. SSA has done as much as possible to limit the flexibility of State examiners in areas where subjectivity is most prevalent, and in this fashion has directed them to deny gray area cases.

### *(6) Pain*

As a medical phenomenon, pain is very poorly understood, and has served as an area of contention in the DI Program. Until recently, the statute was silent on how it was to be treated in the disability determination system. SSA relied on regulations drafted in 1980 that stated that pain is a symptom, not an impairment, and that its existence alone cannot be used as evidence of disability. There must be medical documentation that shows there is a medical condition that could be reasonably expected to produce the pain. As such, objective or subjective evidence is only considered insofar as SSA had identified a cause of that pain.

A number of courts have ruled that this policy is not in comformity with the law, in that pain may be disabling to an individual, regardless of whether its genesis is understood. Severe pain may serve to limit one's ability to perform basic work functions. By not considering pain as a potentially disabling impairment, SSA is not realistically evaluating whether one can or cannot work.

### *(7) State Actions*

A great number of States have revolted against SSA's recent practices and policies relating to the CDI's, and many Governors and State agency administrators have imposed moratoria on the reviews. On March 8, 1983, Massachusetts Governor Dukakis issued an executive order requiring the State disability determination office to implement a medical improvement standard in reviewing cases, as ordered by a district judge in *Miranda* v. *Secretary of HHS*. Arkansas, Kansas, and West Virginia similarly implemented review procedures at odds with official SSA policy. In Kansas, Governor Carlin also ordered reopening and reexamination of all cases terminated since March 1981.

On July 22, 1983, Cesar Perales, commissioner of the New York State Department of Social Services, suspended review pending the establishment of a medical improvement standard. Alabama, New Jersey, Pennsylvania, Michigan, Maine, Illinois, Virginia, North Carolina, Ohio, and New Mexico all initiated moratoria on the reviews. Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, and Washington also initiated temporary or indefinite moratoria. Combined, more than half the States, at the beginning of 1984 were either not processing the reviews, or were conducting them under standards that varied with official SSA procedures and requirements.

This rebellion of the States has been cited by advocates of reforms as an indication of just how completely the DI Program disintegrated, and how urgent was the need for comprehensive reform. Opponents of comprehensive legislation viewed this development as a product of the fact that the States had no real financial stake in DI benefits, which were paid for in total by Federal funds, and that perhaps federalization of the disability determination was in order.

### (C) THE SOCIAL SECURITY DISABILITY BENEFITS REFORM ACT OF 1984

After extensive hearings and consideration of numerous competing proposals, Congress passed a bill which was signed into law on October 9, 1984. The act [Public Law 98-460] included the following provisions:

(1) A medical improvement standards to ensure that benefits could be terminated only of substantial evidence showed that the recipient's medical condition had improved;

(2) A requirement that SSA consider the combined effects of multiple impairments;

(3) A moratorium on mental health reviews until implementation of new mental impairment standards; and

(4) Procedural changes requiring pretermination notices, continuation of benefits during appeal, standards for medical evidence, and other procedural safeguards.

Though the Social Security Disability Benefits Reform Act is a piece of legislation with an unprecedented degree of specificty in the history of the DI Program, its ultimate effect will largely depend on how SSA interprets the statutory language, and how this interpretation will translate into administrative instructions and guidance to State agencies. Predicting how this new law will be work out in day-to-day decisionmaking, and determining what effects it will have on the adjudicative climate is impossible at this point. Further, the Federal courts are inextricably linked to the many of the most important issues in the whole DI crisis, and a number of extremely complicated legal problems will undoubtedly unfold as this legislation is implemented.

The new medical improvement standard raises a number of important questions. Congress attempted to sidestep the problem of who bears the burden of proof in determining continuing eligibility to DI benefits by stating that the decision should be based on the evidence, and neutral to the fact that an individual had been determined eligible in the past. Though a creative solution to a problem that the House and Senate conferees could not agree upon, it raises a number of concerns for implementation. How much evidence must be produced that shows an individual has improved over time? Can a consultative exam by a SSA physician, who has never examined an individual before, determine that this person's condition has improved in relation to the incomplete records the doctor may have available? Does the fact an individual is taking less medication than he had in the past constitute substantial evidence of improvement? If SSA has lost the individual's original case file, which is very frequently the case, what is the obligation of the individual to recreate that file? What if the individual cannot? Questions of this nature remain unanswered, and will depend largely on very concrete internal administrative procedures that SSA issues to the disability examiners in the field.

In concept, a medical improvement standard is a method of ensuring that if the Government is going to declare someone ineligible for benefits, there must be a coherent reason for doing so. In the version of H.R. 3755 that passed the House, the legislative language made it clear that SSA must demonstrate that there is improvement in a beneficiary's medical condition, and that this improvement enables the individual to work. In the House version there was a causal link between the change in condition and ability to work. In the final legislation however, this link is broken. SSA determines whether there has been any medical improvement, and if there has been any, it then determines whether the individual can work under current standards. There is no tie between the event—medical improvement—and the outcome—ability to work.

In both breaking the causal link between medical improvement and capacity to work and sidestepping the issue of burden of proof, Congress attempted to establish something that could be labeled a medical improvement standard while evading the central issues. The basic process of matching an individual's medical records against current standards is the same—all that is new in the law is an elaborately designed hurdle, called medical improvement, that SSA must jump before it terminates eligibility. The fundamental problem of whether or not it is fair to terminate an individual without specifically identifying what change in circumstances led to a new capacity to work is not truly resolved. Nor does Congress make clear its position on whether or not entitlement to benefits establishes a presumption of disability that the Government must rebut. The extent to which the medical improvements standard acts as a procedural safeguard for beneficiaries remains to be seen.

In addition to medical improvement, a few other provisions have the potential for significantly increasing the number of beneficiaries on the rolls. For instance, if the antiquated mental impairments listings are brought into conformity with current medical knowledge, and if an attempt is made to realistically determine whether mentally impaired people can work in a competitive environment, as is required by the legislation, a tremendous number of people will become entitled to benefits. In the past 4 years, it has been almost impossible to receive or sustain benefits on the basis of a mental disability. If this source of excluding people is opened up, it will cost a great deal.

The provision mandating that SSA consider the combined effect of a multiplicity of impairments could also serve to open doors to applicants and beneficiaries that has been shut in the past few years. If SSA allows State agencies flexibility in making realistic determinations of the "total" medical picture, it eliminates one method of terminating a whole class of "gray area" cases.

Another major area of uncertainty will be the response of the courts to the legislation. Though the medical improvement application scheme was drafted with the intention of cleaning the judicial slate by sending back to SSA all individual plaintiffs, all members of certified class action suits, and all named members of noncertified class action suits, it is very hard to predict what the role of the courts will be in the future. It is possible that judges will rule that unnamed members of noncertified class action suits can not be excluded from redress, and that SSA will have to reexamine virtually everyone terminated since 1981. Obviously, this would be costly. It may be that judges will not allow SSA to apply a new standard that is less favorable to beneficiaries than a previously court-ordered standard. There are a number of similar open questions that will have to be answered in the next few years.

### 3. LEGISLATIVE AND ADMINISTRATIVE RESPONSE

Congress enacted virtually no significant legislation in the DI area in 1985. This comes as no surprise given the comprehensive nature of the 1984 Reform Act and the years of extensive and thorough debate which preceded it.

The most significant activity in the DI field took place in the administrative arena with the promulgation of three major sets of administrative rules by SSA. The first set of rules created new standards for evaluating disabilities caused by mental impairments. The rules resulted from extensive interaction between SSA and mental health professionals, particularly the American Psychiatric Association, which led to numerous changes, most notably, an increase in the categories of mental disorders and new standards for medical evidence. SSA published the rules on August 28, 1985 (50 FR 35038).

The second set of rules responded to the mandate of the 1984 Reform Act and created guidelines for the determination of medical improvement as a prerequisite to the termination of benefits. SSA published these rules on December 6, 1985 (50 FR 50118).

The third set of rules revised the medical criteria applicable to the determination of physical disability. The last revision of the physical impairment criteria had occurred in 1979, and the 1985 rules had been in development since 1982, but had been delayed by the need to write medical improvement and mental impairment rules in response to the 1984 Reform Act. SSA published the new physical impairment rules on December 6, 1985 (50 FR 50068).

While SSA published all of the above rules in 1985, complete evaluation of the rules will not be possible until after SSA has applied the new rules to a substantial number of cases, which will probably not occur until at least the middle of 1986. Attention will likely focus on the degree of evidence used to establish medical improvement, and the general stringency or leniency with which the rules are applied. In the final analysis, any expansion or shrinkage of the DI program will depend less on the specific language of the rules, and more on the administrative climate which surrounds the application of the rules to individual cases.

### 4. PROGNOSIS

In the DI program, 1986 will see attention focused primarily on the implementation and effect of the changes wrought by the 1984 Reform Act. Controversy will likely center around the degree, if any, to which the benefit rolls expand, and the efficiency of SSA in handling the large backlog of cases which has accumulated.

# Chapter 2

# EMPLOYEE PENSIONS

## OVERVIEW

Congressional attention to pension issues increased in 1985 with efforts to redesign the pension program for Federal employees and with renewed interest in the funding and adequacy of private pension benefits. Despite the increase in activity, none of the major pension legislation was completed by year's end.

Private pension activity focused on the funding of private plans—particularly the termination of underfunded plans—and on the distribution of benefits in the context of tax reform. Legislation to raise the premium and reform the Pension Benefit Guaranty Corporation's single-employer termination insurance program was agreed upon by a conference committee of the House and Senate. In addition, changes in the tax treatment of retirement plans were proposed in both the President's May 1985 tax reform proposals and in H.R. 3838, passed by the House in December.

In the wake of 10th anniversary reviews of the Employee Retirement Income Security Act (ERISA), several congressional committees began in 1985 to discuss the need for a national retirement income policy. At the same time, legislation was introduced to articulate elements of a national retirement income policy and to improve the adequacy of future retirement benefits.

Congress also made progress in developing a new Federal retirement plan to supplement Social Security for workers hired since 1983. After 2 years of study, the committees of the House and Senate with jurisdiction began work in 1985 on proposals for a new plan. Two different approaches emerged, and by year's end the House and Senate were in conference to work out their differences and report a final bill to the Congress.

By year's end, concern about Federal budget deficits again dominated the agenda. As part of the Gramm-Rudman budget reform legislation, Congress made a last minute decision to withhold the 3.1 percent cost-of-living increase in Federal civil service and military retirement benefits scheduled to go into effect January 1986. By cutting Federal COLA's and providing protection from automatic Gramm-Rudman cuts for Social Security and other income security programs, Congress broke with the concept of equal treatment for Federal and other retirees that had been a tradition in earlier deficit reduction efforts.

# A. PRIVATE PENSIONS

## 1. BACKGROUND

Pension plans are sponsored by employers or unions to provide employees retirement benefits to supplement Social Security. Most pension plans are sponsored by a single employer and provide employees credit only for service performed for the sponsoring employer. However, 17 percent of all private plan participants are in multi-employer plans which cover the members of a union while working for any of a number of employers within the same industry and/or region. Today there are over 800,000 private-sector plans with over 40 million private wage and salary workers participating. Just over half (52 percent) of the private wage and salary workers were covered by an employer-sponsored pension plan in 1983.

Most private plan participants (70 percent) are covered under a defined-benefit pension plan. The rest participate in defined-contribution pension plans. Defined-benefit plans specify the benefits that will be paid in retirement, usually as a function of the worker's years of service under the plan or years of service and pay. The employer makes annual contributions to the pension trust based on estimates of the amount of investment needed to pay future benefits.

Defined-benefit plans generally base the benefit paid in retirement either on the employee's length of service or on his length of service and pay. Fewer than a third (30 percent) of all participants in medium and large size private plans receive benefits based on a fixed dollar amount for each year of service. The majority of the flat-rate plans cover union or hourly employees and are collectively bargained between the union and employer. Most participants are in salary-related plans that base the benefits on a fixed percentage of career average pay or final 3 or 5 years pay.

Workers in private-sector defined-benefit plans are typically in large plans provided as the primary pension plan, funded entirely by the employer. More than three-quarters of the participants in defined-benefit plans are in plans with more than 1,000 participants. The defined-benefit plan where it exists is either the only pension plan the employer offers or the primary plan. The largest employers generally supplement the defined-benefit plan with one or more defined-contribution plans. Where supplemental plans occur, the defined-benefit plan is usually funded entirely by the employer, and the supplemental defined-contribution plans are jointly funded by employer and employee contributions. Defined-benefit plans occasionally accept voluntary employee contributions or require employee contributions. However, less than 3 percent of the contributions to defined-benefit plans comes from employees. Most Government employees participate in large contributory defined-benefit plans.

Defined-contribution plans specify only a rate at which annual or periodic contributions are made to an account. Benefits are not specified but are a function of the account balance, including interest, at the time of retirement. All defined-contribution plans are not strictly speaking "pension plans," in that they are not all intended solely to provide retirement income, although they are all included in ERISA and Internal Revenue Code definitions of plans subject to tax-qualifications and fiduciary requirements.

Private pensions are provided voluntarily by employers. Nonetheless, the Congress has always required that pension trusts receiving favorable tax treatment benefit all participants without discriminating in favor of the highly-paid. Pension trusts receive favorable tax treatment in three ways: (1) Employers deduct their contributions currently even though they are not immediate compensation for employees, (2) income is earned by the trust tax-free, and (3) employer contributions and trust earnings are not taxable to the employee until received as a benefit. The major tax advantage, however, is the tax-free accumulation of trust interest ("inside build-up") and the fact that the tax on benefits is usually at a lower rate than it would have been if levied on the contributions when made.

In the last decade the Congress has increasingly used the special tax treatment as leverage to encourage widespread coverage and benefit receipt. In the Employee Retirement Income Security Act [ERISA] of 1974, Congress first established minimum standards for pension plans to ensure broad distribution of benefits and limited pension benefits for the highly-paid. ERISA also established standards for funding and administering pension trusts, and added an employer-financed program of Federal guarantees for pension benefits promised by private employers.

In 1982, Congress sought, in the Tax Equity and Fiscal Responsibility Act (TEFRA), to prevent the fact of discrimination in small corporations by requiring so-called "top heavy" plans to accelerate vesting and provide a minimum benefit for short-service workers.

In 1984, Congress enacted the Retirement Equity Act [REA] to improve the delivery of pension benefits to workers and their spouses. REA lowered minimum ages for participation to 21, provided survivor benfits to spouses of vested workers, and clarified the division of benefits in a divorce.

As of 1984, private pension funds totaled $917 billion and accounted for 42 percent of the institutional assets in the economy. In 1985, Federal tax expenditures for public and private employer-sponsored pensions cost the Government $71 billion.

## 2. Issues

### (A) BENEFIT ADEQUACY

The goal of retirement plans is to replace a worker's preretirement earnings with sufficient benefits to maintain his or her standard of living into retirement. The President's Commission on Pension Policy recommended in 1981 that to achieve this goal, the worker earning the average wage would need income from pensions, Social Security, and other sources equal to 60 to 75 percent of pre-retirement earnings.

The President's Commission also recommended that "replacement ratios" for low wage earners should be higher than for high wage earners. The replacement ratio needed to maintain a reasonable standard of living declines with higher earnings because it is thought that the highly-paid can live with less more easily than the low-paid who already consume only necessities.

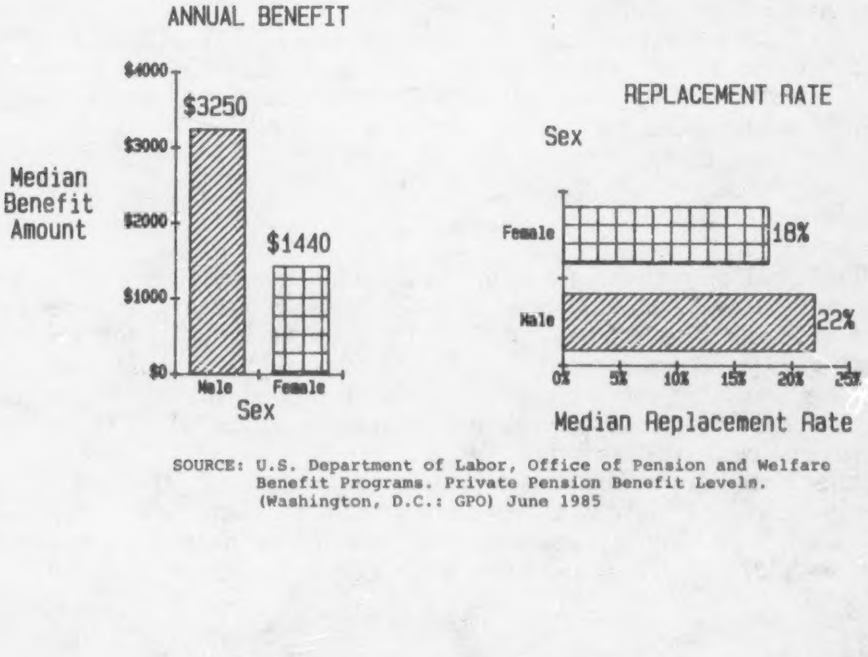
Pensions are usually intended to add benefits to Social Security to bring workers' retirement incomes up to an adequate level of income replacement. Because Social Security provides a higher replacement to low-paid workers, pensions often "tilt" their benefits the other way—providing a higher replacement to the higher paid. For example, a minimum wage worker receiving 54 percent of preretirement earnings from Social Security would only need to replace 20 to 35 percent of pre-retirement earnings from a pension to meet the Pension Commission's goal of 75 to 90 percent replacement. On the other hand, a worker at the Social Security taxable maximum would need to replace 35 to 50 percent of preretirement earnings from a pension.

Older Americans today get relatively little income from pensions. Three-fourths of those 65 and older receive no pension benefits. Only 15 percent of the income the elderly receive in total comes from pensions.

Average benefit levels from pension plans tend to be low. A Labor Department study of recent retirees from private pension plans projected the median annual benefit of 1977-78 retirees from the plan to be $2,650. This benefit replaced, at the median, 21 percent of pre-retirement earnings. Benefit levels for women were even lower—the median annual pension for women was 44 percent of that for men, largely due to lower career earnings.

CHART 2-1

MEDIAN PENSION BENEFITS FROM FINAL PENSION PLAN BY SEX
WORKERS RETIRING WITH PENSIONS IN 1977-78



SOURCE: U.S. Department of Labor, Office of Pension and Welfare Benefit Programs. Private Pension Benefit Levels. (Washington, D.C.: GPO) June 1985

The generation of workers retiring today are benefiting somewhat more from the pension system than previous retirees. Nearly half of the families who retired on Social Security in 1980 and 1981 are receiving some income from pensions, although one-half of these receive less than $400 a month in benefits from all their pensions combined.

Three factors are most likely to cause low pension benefits: Movement in and out of the labor force or pension-covered employment, job mobility and the length of stay on any one job, and features of pension plan formulas that may reduce pension benefits.

Career patterns have the greatest effect on the amount of benefits paid by pension plans. Workers who enter plans late in life or work short periods under a plan earn substantially lower benefits than those who enter early and work a full career. The Labor Department study found that the median benefit for workers with 10 years of service under their last pension plan replaced only 6 percent of their pre-retirement income while the median benefit of those with 35 years of service replaced 37 percent of pre-retirement income. Similarly, workers who entered the plan at a young age accumulated larger pensions than those who entered the plan late in life.

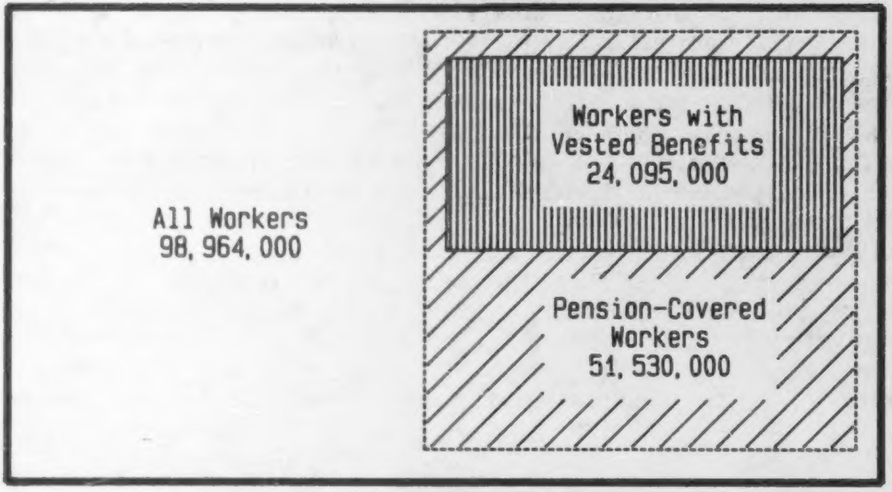
### *(1) Coverage*

Employers or unions voluntarily sponsor pension plans to provide workers with benefits supplementing Social Security in retirement. Today only half (52 percent) of all American workers are covered by a pension plan sponsored by their employer. In total, 47 million workers are not covered by a pension plan, either because they work for an employer who does not have a pension plan, or because they are excluded from participating in the employer's plan.

Employers who offer pension plans do not have to cover all of their employees. The law governing pensions—ERISA—permits employers to exclude part-time, newly-hired, and very young workers from the pension plan. In addition, the law only requires employers to cover, at most, 70 percent of the remaining workers (only 56 percent if employees have to contribute in order to participate in the plan); and an even smaller percentage of workers if the classification of workers they exclude does not result in the plan discriminating in favor of the highly-paid.

CHART 2-2

PENSION COVERAGE AND VESTING
TOTAL U.S. WORKFORCE
MAY 1983



Source: Emily S. Andrews. The Changing Profile of Pensions in America (Washington, D.C.: EBRI) December 1985

Most noncovered workers, however, work for employers who do not sponsor a pension plan. A large proportion of the noncovered workers (nearly three-quarters) work for small employers. Small firms tend not to provide pensions because a pension plan can be administratively complex and costly, often these firms have low profits margins and uncertain futures, and the tax benefits of a pension plan for the company are not as great for small firms.

Projections of future trends in pension coverage have been hotly debated. However, it seems unlikely that pension coverage will grow much without some added incentive for small business to add pension plans and for employers to include part-time workers in their plans. The expansion of pension coverage has been slowing steadily over the last few decades. The most rapid growth in coverage occurred in the 1940's and 1950's when the largest employers adopted pension plans. In recent years, coverage has actually declined slightly due to recession, the loss of jobs in the well-covered manufacturing sector, and the increase in jobs in the poorly-covered service sector.

### *(2) Vesting*

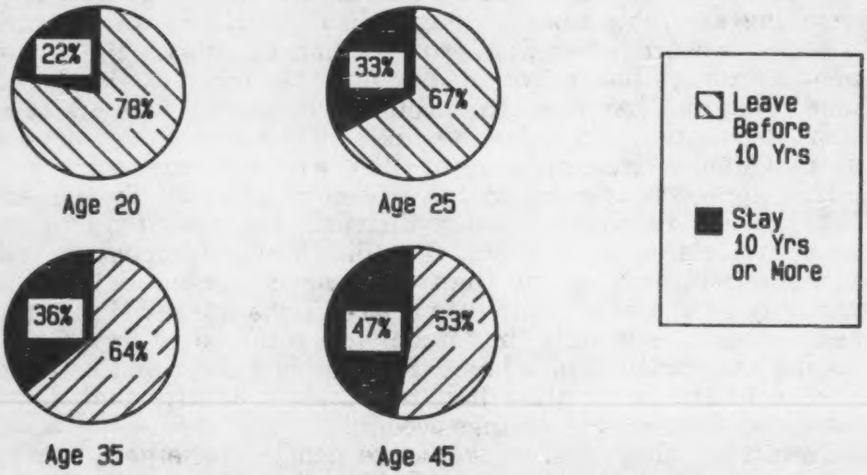
Vesting is earning the right to receive benefits from a pension plan. Someone who is merely covered by a pension plan will not necessarily receive any benefits from that plan. To receive benefits the worker must vest under the plan.

Vesting is one of the features of a pension plan intended to encourage employees to stay with the company. Hiring and training workers can be costly to employers. To reduce job turnover and keep good workers, employers often hold out the promise of better compensation in the future. A pension is one way for a company to systematically reward worker loyalty without causing resentment among other workers.

Vesting provisions are a simple way to make sure benefits do not go to short-term workers. Because the rules are clear to workers, vesting rules have been shown to be effective in reducing the rate of job quits among those who are a few years short of vesting.

CHART 2-3

PERCENTAGE OF FULL-TIME MALE WORKERS REMAINING ON THE JOB TEN YEARS BY AGE OF JOB ENTRY



SOURCE: David L. Kennell and John F. Sheils. Revised Documentation of the ICF Pension and Retirement Simulation Model (Washington, D.C.: ICF Incorporated) February 1984

The majority of workers today do not stay with the same employer the number of years required to earn a benefit in most pension plans. Currently, nearly 80 percent of pension-covered workers are covered by plans that do not fully vest (provide a nonforfeitable right to a benefit) before 10 years, and more than 60 percent are in plans that vest no benefit before 10 years. The probability that a worker starting a job will remain on the job for 10 years is low. Full-time male workers have the longest average job tenures; and even then, only one male in two starting at age 45, will stay 10 years.

Workers today are having a more difficult time earning pensions than their predecessors because job tenure is on the decline. The average job tenure for a male aged 40–44, for example, has dropped from 9.5 years in 1966 to 8 years in 1981. Women's average job tenures are declining less rapidly—but already tend to be much shorter than men's. Job tenure for women aged 40–44 dropped from 4.1 years in 1966 to 3.9 years in 1981.

### *(3) Benefit Distribution and Deferrals*

When workers change jobs, earned pension benefits can be lost. As a result, much of the money being accumulated for retirement is not being retained to provide retirement income.

Vested workers who leave an employer before retirement usually have the right to receive "vested deferred benefits" from the plan when they reach retirement age. Benefits that can only be paid this way are not "portable" in that the departing worker may not transfer the benefits to his next plan or to a savings account. Many pension plans, however, allow a departing worker to take a lump-sum cash distribution of his or her accrued benefits.

Federal policy on lump-sum distributions has been inconsistent. On the one hand, Congress has encouraged lump-sum distributions by permitting employers to make mandatory distributions without the consent of the employee on amounts of $3,500 or less; and by providing favorable tax treatment through the use of the unique "10-year forward averaging" rule (which calculates the tax payment as though the individual has no other income). On the other hand, Congress has tried to encourage departing workers to save their distributions by deferring taxes if the amount is rolled into an individual retirement account (IRA) within 60 days.

This approach appears to have been ineffective. To the extent that workers receive lump-sum distributions, they tend to spend them rather than save them; thus distributions appear to reduce retirement income rather than increase it. Recent data indicate that only 5 percent of lump-sum distributions are saved in a retirement account, and only 32 percent are retained in any form, including the purchase of a home. Even among older and better educated workers, fewer than half roll their pre-retirement distributions into a retirement savings account.

Even when they vest, workers lose pension benefits under some plans when they change jobs. The pension loss results from the way some plans accrue benefits. Final-pay formulas have been popular with employers because they relate the pension benefit to the worker's earnings immediately preceding retirement. However, final-pay plans penalize workers who leave the plan before retirement by "freezing" benefits at the last pay level under the plan. The further a worker is from retirement, the less valuable the pension benefits will be. A mobile worker earning benefits under a number of final-pay plans will receive much lower benefits than a steady worker who spends a full career under a single plan.

### *(4) Integration*

Current rules permitting employers to reduce pension benefits to account for Social Security benefits can result in an excessive reduction or even elimination of a lower-paid worker's pension benefits. Under the Social Security Program, workers pay a uniform tax rate but receive Social Security benefits that are proportionately higher at lower levels of income. Employers who want to fit their pension benefits together with Social Security benefits to achieve a more uniform rate of income replacement for their retirees use integration to accomplish this goal. The integration rules define the amount of adjustment a plan can make to pension benefits before the plan is considered discriminatory.

Under current rules, pension integration can be used unfairly and can deprive workers of legitimate benefits. In general, there are two types of integration—excess and offset. In excess integration, the plan pays a higher contribution or benefit on earnings above a particular level (the "integration level") than it pays on earnings below the level; current rules permit the plan to pay nothing below the integration level. In offset integration, the plan reduces the pension benefit by a percentage of the Social Security benefit; current rules limit the percentage of Social Security that can be used but do not prevent the elimination of the pension altogether. Current rules are also out-dated and overly complex. They make it impossible for pension participants to understand what is happening to their pension benefits.

### (B) TAX EQUITY

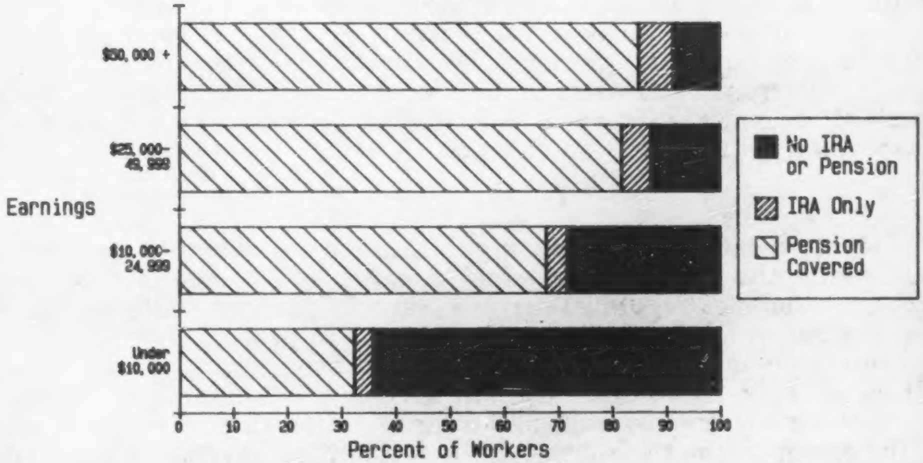
Private pensions are encouraged through tax benefits now estimated by the Treasury to equal roughly $45 billion a year. In return, Congress regulates private plans to prevent overaccumulation of benefits by the highly paid. Efforts to prevent discriminatory provisions of benefits have focused recently on the potential for discrimination in voluntary group savings plans and on the effectiveness of current coverage and discrimination rules.

In recent years, there has been a substantial increase in tax-free individual contributions to retirement and savings plans. Prior to 1974, only employees of public or tax-exempt organizations could elect to defer some of their salary without paying income taxes on it through a tax-sheltered annuity (TSA) (under section 403(b) of the Internal Revenue Code). Private sector employees could only make after-tax contributions to a retirement plan. Beginning in 1974, the Congress gradually extended the opportunity to make tax-free elective deferrals to all employees. Legislation was enacted in 1974 permitting workers not covered by an employer-sponsored pension plan to defer up to $2,000 a year to an individual retirement account (IRA). Then, in 1978, cash or deferred arrangements (CODA's) were authorized for private employers under code section 401(k). Workers covered under a CODA may make elective tax-free contributions (by agreeing with the employer to reduce their salaries) to an employer plan. The amount that any worker can contribute is limited by the total limit on all pension contributions (25 percent of salary up to $30,000) and by a separate nondiscrimination test for 401(k) plans restricting the amount deferred by highly paid workers to a ratio of the amount deferred by lower-paid workers. Finally, in 1981 Congress opened up the opportunity to defer $2,000 a year in an IRA to all workers.

Concern has grown in recent years that tax-free voluntary savings may offer too great a tax shelter for the highly paid and may be inequitable. The tax benefits of voluntary savings are most attractive to those in the highest tax brackets. While a large portion of the tax benefit goes to those who would probably save for retirement without it, many who need the retirement savings do not benefit from the tax provisions. In addition, the aggregate tax benefits for savings may have become excessive. Currently, the bulk of those using IRA's already participate in a corporate pension or 401(k) plan and could be preparing adequately for retirement without an IRA.

CHART 2-4

COVERAGE BY RETIREMENT PLANS
BY EARNINGS
1983



SOURCE: Emily S. Andrews. The Changing Profiles of Pensions in America (Washington, D.C.: EBRI) December 1985

Nondiscrimination rules are intended to ensure that employee benefit plans that are tax-favored are of benefit to a broad cross-section of employees and not just the highly paid. Corporate pension and deferred compensation plans are required to meet a number of nondiscrimination tests for coverage and comparability of benefits as set forth in sections 401 and 410 of the Internal Revenue Code (and various revenue rulings) to become tax-qualified. Plans are required to benefit either 70 percent of the employees who meet age and service requirements (56 percent in a contributory plan) or a classification of employees that the Secretary of Treasury finds not to be discriminatory. Benefits provided in one or a number of plans by the same employer must be reasonably comparable (in relation to pay) at various pay levels.

CODA's, in which participation is optional for the employee, must meet an additional nondiscrimination test based on the use of the plan, to ensure that the highly paid are not benefiting disproportionately from the plan. Under current law, the top one-third of employees, by pay, cannot defer more than 1.5 times the average proportion of salary that the lower paid two-thirds actually defer.

In the last few years, concern has emerged that the current coverage rules are too loosely structured and have been weakened too much through revenue rulings to ensure broad participation in employer plans by lower paid workers. In addition, there has been some concern that the current CODA discrimination rules permit excessive deferrals by the highly paid in relation to the amounts actually deferred by the lower paid. Tax-sheltered annuities have not even come under current nondiscrimination requirements since these were established under a separate code section (section 403(b)).

### (C) PENSION FUNDING

The contributions plan sponsors set aside in pension trusts are invested to build sufficient assets to pay benefits to workers throughout their retirement. The Federal Government, through the Employee Retirement Income Security Act of 1974 [ERISA], regulates the level of funding and the management and investment of pension trusts. Under ERISA, plans that promise a specified level of benefits (defined benefit plans) must have enough assets to meet benefit obligations earned to date under the plan or must make additional annual contributions to reach full funding in the future. Plans created since 1974 are required to reach full funding within 30 years. Plans predating ERISA were allowed 40 years to develop full funding. Under ERISA, all pension plans are required to diversify their assets, are prohibited from buying, selling, exchanging, or leasing property with a party-in-interest, and prohibited from using the assets or income of the trust for any purpose other than the payment of benefits or reasonable administrative costs.

Prior to ERISA, participants in underfunded pension plans lost their benefits when employers went out of business. To correct this problem, ERISA established a program of termination insurance to guarantee the vested benefits of participants in single-employer defined benefit plan. This program guarantees benefits up to $1,790 a month (1986) (adjusted annually). It is funded through annual premiums of $2.60 per participant (as of 1985) paid by employers to a nonprofit Government corporation—the Pension Benefit Guaranty Corporation (PBGC). When an employer terminates a plan, the PBGC receives any assets in the plan, and may make a claim against additional assets up to 30 percent of the employer's net worth. A similar termination insurance program was enacted in 1980 for multiemployer defined benefit plans, using a slightly higher annual premium, but guaranteeing only a portion of the participant's benefits.

In 1985, congressional attention focused on three concerns about pension funding. The most pressing concern was increasing termination of plans with large unfunded liabilities and the resulting need for reform and a premium increase for the single-employer termination insurance program. In addition, there was a growing concern about the termination of overfunded plans by employers to recover excess pension assets. Finally, public attention began to focus on what some consider the poor investment performance of pension funds.

#### *(1) Termination of Underfunded Plans*

Over the last 5 years, there has been increasing concern that the single-employer termination insurance program, operated by the

PBGC, is inadequately funded. The PBGC began to seek congressional approval for a premium increase in May 1982. By the end of fiscal 1984, PBGC had liabilities of $1.5 billion and assets of only $1.1 billion—leaving a deficit of $462 million. Projections at that time indicated that without a premium increase the fund for single-employer plans would be exhausted by 1990. During 1985 the PBGC assumed $615 million in additional liabilities.

The Congress responded to a much smaller deficit in 1978 by simply raising the annual premium from $1 to $2.60 per participant. This time, however, employers, labor organizations, and the administration worry that the program itself is flawed, and without reform, premium increases could be never-ending.

A major cause of the PBGC's problem has been the ease with which economically viable companies can terminate underfunded plans and dump their pension liabilities on the termination insurance program. Currently, employers who are unable to make required contributions to the pension plan can request a "funding waiver" from the Internal Revenue Service [IRS]. These waivers permit troubled companies to increase their unfunded liabilities. Once underfunding becomes a financial burden to a company, they can terminate the plan and transfer the liability of the PBGC. The PBGC is helpless to prevent the termination, and may seek to collect additional amounts from the company only up to 30 percent of the company's net worth. Often this amount is far less than the pension liability transferred to the PBGC.

Terminations of underfunded pension plans also reduce the benefits paid to participants and beneficiaries. Even though vested benefits are generally insured by the PBGC, the termination insurance program does not protect all benefits vested in underfunded plans. Employees are often in a difficult position when an employer terminates an underfunded plan. On the other hand, the inability of the company to restructure its debt may force the company to go out of business and the workers to lose their jobs.

In 1985, the PBGC assumed the two largest claims in the program's 11-year history—both of which illustrate fundamental weaknesses in the termination insurance program. In July, the Allis-Chalmers Corp. ended its pension fund with liabilities of $165 million and assets of only $5 million, having managed to fund only 3 percent of the benefits it promised. In October, the Wheeling-Pittsburgh Steel Corp., which had filed in April for reorganization under chapter 11 of the Bankruptcy Code, announced its intention to terminate its two pension plans, with unfunded liabilities of over $450 million. In both cases, the companies are likely to become or remain profitable in the future, in part because they have succeeded in dumping pension liabilities on the PBGC. The result is that other employers (including their competitors) through their premiums to the PBGC, and participants in the plan through some loss in benefits will subsidize the future profitability of these companies.

Criticism of the termination insurance program has focused on four issues. First, should companies that are not in financial hardship be able to terminate an underfunded plan and dump liabilities on the PBGC? Second, if a company requests a "funding waiver," should they be required to put up some type of security for the reduced contributions? Third, if a company avoids its pension liability by selling or transferring a financially troubled subsidiary, should the PBGC be able to make a future claim against the parent company if the plan is later terminated? Fourth, should a company that terminates its plan in financial distress have additional liability to the PBGC if they later become profitable?

### *(2) Reversions of Assets From Termination of Overfunded Plans*

Concern in the Congress continued to grow in 1985 over the termination of well-funded defined benefit pension plans to enable plan sponsors to recapture the surplus assets. Under ERISA, sponsors of plans with assets that exceed ERISA funding standards can recover these surplus assets over time by reducing their contributions to the plan. Withdrawals of assets are not permitted as long as the plan remains in operation. Employers can recover assets, however, when a plan is terminated.

In recent years, a substantial increase in plan surpluses due to gains in both the stock market and the bond market declining interest rates, and increasing awareness of the potential for recovering plan assets, has caused employers to consider terminating well-funded defined benefit plans for a variety of business reasons unrelated to the purposes of the retirement plan. The major reasons for termination have included: Financing or fending off a corporate takeover, improving cash flow or redirecting the company's assets, and replacing the defined benefit plan with a defined contribution plan.

Originally, employers were loathe to terminate pension plans simply to recover assets because of a concern that plan participants might lose benefits and the PBGC would prevent them from offering a similar successor plan. The issuance of Implementation Guidelines for Asset Reversions by the PBGC, Treasury Department, and Department of Labor in May 1984 helped clarify that an employer could terminate one plan and establish a similar successor plan as long as all plan participants were vested and benefits were fully covered under annuity contracts. This clarification has given rise to a host of new plan terminations that have left participants covered under identical or similar successor plans.

The number and size of reversions from plan terminations has been increasing steadily in recent years. Since 1979, 780 pension plans have terminated with a reversion of more than $1 million. As of December 31, 1985, an additional 279 requested plan terminations were pending PBGC approval. Employers have recaptured $7.9 billion in surplus assets with an additional $2.7 billion pending. In 1985 alone, 435 plans were terminated or pending with a total of $5 billion reverted or will revert to employers from these plans, an average of $13.6 million per plan. The largest reversion ever to occur was the reversion in 1985 of over $962 million to United Airlines through the termination of 5 pension plans. Reversions from the termination of defined benefit plans are likely to continue to accelerate due to the substantial excess in pension funding. Currently, the 200 largest companies by sales have an estimated $73 billion in liquid pension assets.

Employers who are terminating pension plans to recover assets usually set up a replacement plan to continue pension coverage for participants. Data from the PBGC on pending terminations as of September 1985 shows that in 85 percent of the proposed plan terminations, the participants were to remain covered under the old or a successor plan. In half of the cases, coverage continued under a defined benefit plan; in a third of the cases, participants were covered under a defined contribution plan.

The two common methods for leaving participants covered under a defined benefit plan—"spinoff" termination and "re-establishment" termination—essentially leave participants benefits unchanged. Under a "spinoff," the old pension plan is split into two plans—one covering retirees and the other active employees. Active employees remain in the old plan. The surplus assets are placed in the retiree plan, the retiree plan is terminated, and annuities are purchased for the retirees. Under a "re-establishment," the old pension plan is terminated and a new similar plan is set up, with past service credits normally provided in the new plan for all active employees. By using either approach, employers are doing in two steps what they would *not* be allowed to do in one step. Many have argued the "step transaction doctrine" whereby if actions taken in two transactions have basically the same result as could have been obtained in a single transaction, which would have been disallowed, then the two transactions should not be allowed. However, if the "doctrine" is applied, the employer will then have a strong incentive to completely terminate the plan with no form of reestablishment. There is agreement that defined benefit plans are advantageous for employees and that their continuation is to be encouraged. The extension of the argument is that the plan sponsors not be forced into a position whereby they have to "play games," and further that the current two-step withdrawal be allowed in one step, thereby eliminating the necessity to terminate the existing plan. Since benefits often remain unchanged, there is disagreement over whether reversions are in fact a serious problem. Critics argue that retirees can be harmed in a spinoff termination because they lose the potential for future cost-of-living increases in their benefits. They also contend that reversions draw needed, as well as surplus, assets from the plans and may increase the risk for the PBGC because newly created plans are not required under ERISA to maintain a funding level as high as plans that have been in existence for some time.

Plan sponsors counter that the real problem is that employers have to terminate pension plans in order to recover surplus assets the should be able to have without termination. Since the company, in a defined benefit plan, promises specified benefits to employees, only the benefits earned to date—not the assets in the plan—belong to the participants. Employers are responsible for adequately funding these benefits and should be permitted to recover funds not needed to pay benefits. Under current law, employers can reduce their contributions to recover surpluses over time. Employers argue they should not have to wait.

Some of the assets recovered in a defined benefit plan termination would not be surplus assets if the plan was going to continue. Some observers have suggested that the recovery of these additional assets is weakening the funding of pension plans and undermining the purposes of the ERISA funding standards. They have proposed that sponsors should be permitted to recover the assets not needed on a continuing basis but be prevented from recovering additional assets if they are going to continue coverage for their employees under a successor plan.

### *(3) Investment Performance of Pension Funds*

Over the last few decades, pension funds have become one of the largest single-purpose pools of capital in the economy. There is now nearly $1 trillion in liquid assets in private pension funds—29 percent of the total funds available for investment in the economy. These funds are becoming increasingly important, not just to the 75 million workers who depend upon them for future retirement income, but for the economy and investment strategies as well. While the investment performance of these pension funds is important, increasingly these funds are becoming a focus of other policy concerns as well.

In January 1985, the Department of Labor held a series of hearings on investment and governance issues related to private pension plans. The published conclusions from these hearings noted that pensions are becoming a dominant factor in stock trading markets. The growth in pension funds were viewed as coincident with an increase in daily trading on the Stock Exchange, annual turnover rates of up to 70 percent of pension funds a year, and a growing trend toward corporate takeovers. As the decisionmaking about pension fund investment has taken on more significance in the context of general corporate finance, there is a growing concern that the relationship to retirement income delivery is weakening. The concern is the extent to which ERISA's restrictions of pension fund investment—the "prudent man'" rule and prohibited transaction restrictions—may be compromised by the rush to "put the money to good use."

Attention has begun to focus on the performance of pension funds relative to that of other institutional investors. There is a growing perception that pension funds have generally done poorly and that money managers are failing to achieve above average returns on their clients' funds. SEI Funds Evaluation Services data shows that nearly three-quarters of the pension fund money managers failed to outperform the Standard and Poors 500 index (S&P 500) in 1984, and over the last decade, the majority (56 percent) of money managers have failed to outperform the S&P 500. Plan sponsors pay $6 billion a year to money management firms to outpace the market, yet most fail to achieve even average returns. With plan sponsors eager to produce high returns and most money managers having difficulty consistently outpacing the market, plan sponsors have engaged in a flurry of account switching and stock-churning. The switch in managers itself can eat up 1 to 2 percent of the value of the account. The net result has been high transaction costs of low yields. Some plan sponsors have begun to pursue more conservative investment strategies, such as buying portfolios that match the composition of the S&P 500, in an effort to improve on poor returns.

A final investment issue has been whether the vast pool of pension assets should be directed to serve social purposes, quite apart from the purpose they now serve in providing retirement income. Generally, social investments are investments that earn a lower rate of return than they might otherwise but which further a particular social end. Alternatively, social investments may be strategies that focus on placing capital where it is needed—possibly at a higher risk and with a potentially high yield—for economic reasons beyond those of improving fund performance. In both cases, the future benefits of participants are put partially at risk to serve goals beyond those of providing retirement income. In recent years, there has been pressure on the Department of Labor to make it easier—through comprehensive plan asset regulations—to invest in real estate, venture capital, and oil and gas partnerships. As the pool of pension funds grows, the pressure to use these assets for social purposes increases.

## 3. LEGISLATION

### (A) TAX REFORM ACT OF 1985 (H.R. 3838)

Pension changes proposed as part of tax reform dominated the pension agenda throughout 1985. The effort to reform the tax code to improve its fairness and simplicity began in earnest with the release of the Treasury Department's report to the President in November 1984. Recommendations included in the report were modified and incorporated in the President's tax proposals issued in May 1985. A subsequent set of proposals, prepared by the staff of the Joint Committee on Taxation, were provided to the chairman of the House Ways and Means Committee in September. These proposals became the basis for the committee's markup of a tax reform bill from September through November. On December 3, the House Ways and Means Committee reported H.R. 3838, the Tax Reform Act of 1985, which was passed by the House on December 17 and sent to the Senate. The Senate Finance Committee is expected to take up the Tax Reform bill early in 1986.

Title XI of H.R. 3838 makes major changes in pension and deferred compensation plans. The stated purpose of these pension proposals is to establish uniform pension rules, restrict tax benefits to plans providing income in retirement, and limit accumulations and prevent the discriminatory use of tax-favored retirement plans by the highly paid. In addition, some pension provisions are structured to raise a substantial amount of revenue to compensate for the cost of other provisions in the tax reform bill. The major changes in the tax treatment of pension and capital accumulation plans fall into four general areas: (1) Limitations on tax-favored voluntary savings, (2) restrictions on distributions, (3) tightening of nondiscrimination rules, and (4) reductions in maximum amount of benefits and contributions in tax-favored plans.

#### *(1) Limitation on Tax-Favored Voluntary Savings*

The House bill tightens the limits on voluntary tax-favored savings plans in an effort to target limited tax resources where they are most needed; and establishes more uniform rules for plans using salary reduction. Employees' elective contributions to both 401(k) and 403(b) plans would be limited to $7,000 per year. Any amounts contributed by an individual through salary reduction would reduce dollar-for-dollar the individual's deduction for IRA contributions.

### *(2) Nondiscrimination Rules*

To broaden coverage and eliminate a perceived potential for abuse, the House bill has made several changes in current nondiscrimination rules. Since no agreement could be reached in committee on the weaknesses of the current coverage rules, H.R. 3838 calls for a study of the effect of the present-law coverage tests. However, H.R. 3838 would substantially tighten nondiscrimination rules covering participation in voluntary savings plans. The 401(k) nondiscrimination test would be tightened by narrowing the definition of the highest paid group and reducing the ratio between the deferral of the top group and the deferral of the bottom. The new nondiscrimination test would limit the average proportion of pay deferred by "highly compensated" employees (owners, those in the top 10 percent by pay, or those earning more than $50,000) to 125 percent of the average proportion of pay deferred by the non-highly compensated. In addition, employer contributions to TSA's would become subject to current nondiscrimination rules covering corporate plans. In addition, elective contributions would have to be available to all employees without the requirement that the employee make a minimum contribution. Finally, H.R. 3838 would extend the 401(k) nondiscrimination rules to thrift and savings plans that do not benefit from tax-free employee contributions.

### *(3) Distribution Rules*

How and when a plan distributes benefits to employees has come to be recognized as a key factor in that plan's ability to deliver adequate benefits in retirement. Traditionally, different types of plans have distributed their benefits in different forms. Defined benefit pension plans (plans that specify the benefits) have generally provided distributions only in the form of an annuity at retirement, while defined contribution pension, profit-sharing, or thrift plans (plans that specify the amount contributed) have generally provided distributions as a lump sum payment whenever the employee leases the company. Current tax law provides special tax treatment for lump sum distributions—both under the IRA rollover rules if they are saved in a retirement account and under the 10-year forward averaging and capital gains rules without regard to how they are used.

Current policy regarding distributions is often criticized for encouraging the consumption of pre-retirement distributions and the loss of retirement savings. While not all employer plans are designed solely to provide retirement income, many of those that are, provide lump-sum distributions for many circumstances other than retirement.

The House tax bill would establish substantial disincentives to use pension or deferred compensation plan accruals for any purpose other than providing a stream of retirement income. The bill would impose an excise tax of 15 percent on distributions from a qualified plan before age 59½, other than those taken as a life annunity or in the event of death or disability. Additionally, the bill would repeal the special tax-treatment for lump-sum distributions now permitted under the 10-year-forward-averaging and capital gains rules. Finally, the bill would modify the tax treatment of distributions from plans with after-tax employee contributions. Previously taxed employee contributions may now be recovered tax-free out of a pension or deferred compensation plan before taxes are applied to any remaining amount. The House bill would repeal the provisions that permit an initial recovery of previously taxed contributions, and would require that taxes be paid on a pro-rata share of the total benefit not attributable to previously taxed contributions.

### *(4) Limitations on Benefits and Contributions*

The amount of additional accumulation an individual can have each year in a tax-favored plan is limited under Section 415 of the Internal Revenue Code. Under current law, the annual benefit payable from a defined plan cannot exceed 100 percent of an individual's compensation (up to a maximum benefit of $90,000). The annual contribution made to a defined contribution plan cannot exceed 25 percent of compensation (up to a maximum of $30,000). If an employee participates in both defined benefit and defined contribution plans, their total accumulation is subject to a combined limit. Although the dollar limits are currently frozen, beginning in 1988 they will be indexed for post-1986 cost-of-living increases.

In recent years, the Congress has reduced and frozen the section 415 limits largely in an effort to raise revenue for the Federal Government in the context of deficit reduction. The House tax reform bill would further reduce and freeze benefit contribution limits in an effort to provide revenue for the tax package. Under the House bill, the defined benefit dollar limit would be reduced from $90,000 to $77,000, with indexing resuming, as under current law, in 1988. The defined contribution dollar limit would be reduced from $30,000 to $25,000, and would remain frozen until the defined benefit limit becomes four times the amount of the defined contribution limit.

To reduce the potential for an individual to over-accumulate by using several plans, the House bill would retain the current law combined limit and would add a 15 percent excise tax to recapture the tax benefits of annual benefits (including IRA withdrawals) in excess of 125 percent of the defined benefit limit ($112,500 currently).

The pension provisions of the House tax reform bill are intended to limit tax benefits for employer-sponsored plans to those providing retirement benefits, to improve the uniformity of incentives for different types of employers and plans, and raise revenues for the total tax package. These issues will come before the Senate in 1986.

### (B) RETIREMENT INCOME POLICY ACT OF 1985 (S. 1784/H.R. 3594)

Legislation to improve future retirement benefits was introduced in the Senate by Senators Heinz and Chafee (S. 1784) and in the

House by Representative Clay (H.R. 3594) on October 22, 1985. Hearings were held on the bill in the Senate Finance Committee January 28, 1986, and in the House Education and Labor Committee February 27, 1986.

The Retirement Income Policy Act [RIPA] provides a statement of retirement income policy goals explaining that its purpose is to strengthen employer-sponsored and financed retirement plans, to support voluntary savings as a supplement to employer-financed plans, and to encourage employer plans to meet the needs of workers with a variety of career patterns. Specifically, the bill would seek to expand pension coverage, improve benefits for short-term and low-paid workers, simplify pension rules where possible, and focus tax incentives on encouraging fundamental retirement income programs.

The central concept in the legislation is that plans designed to provide benefits in retirement should receive greater emphasis than those providing for general savings. Retirement plans would have more favorable tax treatment, but more limited distributions before retirement than non-retirement savings plans. These differences reflect a long-standing distinction in the Internal Revenue Code (IRC) between pension plans and profit-sharing or stock bonus plans. Pension plans are essentially plans that do not provide in-service distributions to workers, while profit-sharing and stock bonus plans provide fairly ready access to the money. RIPA would require that workers having the chance to save in a non-retirement savings plan first be covered under a retirement plan.

The legislation would make several specific changes in rules on coverage, vesting, distributions, integration, and contribution and benefit limits:

*Coverage.*—RIPA would broaden pension coverage in two ways. First, current coverage rules for retirement plans would be tightened. Under current law, employers have a choice of covering 70 percent of their workers of even fewer if they can show that in covering only a small number of employees they do not discriminate in favor of officers, shareholders, or the highly paid. RIPA would permit employers to subdivide their workforce by "business division," but would require that in any business division where they provide a retirement plan they cover all employees (other than those currently excluded by statute) with wages below the Social Security wage base ($39,600 in 1985) under that or a similar plan. In the aggregate of all business divisions, RIPA would require that retirement plans cover 80 percent of these workers. Second, RIPA would improve the incentives for small employers without retirement plans to adopt simplified employee plans (SEP), by permitting employees to make taxfree contributions.

*Vesting.*—ERISA currently requires that plans meet one of three alternative rules in vesting participants. If no part of the benefit vests before 10 years, then benefits must be fully vested in 10 years. Full vesting can occur later under other rules. RIPA would require that under all vesting methods, benefits must be fully vested in 5 years.

*Distributions.*—RIPA would require that retirement plans distribute benefits to participants only at retirement (except in the event of death or disability). Distributions to participants could be made in a "retirement income form" prior to age 59½, in any other form only after age 59½. Distributions at separation of service prior to retirement would have to be made by direct transfer to an IRA or other plan. RIPA would also repeal favorable tax treatment for lump-sum distributions and would raise the IRA early withdrawal penalty from 10 to 20 percent.

*Integration.*—Plans can now adjust the pension benefits they provide to take into account actual or anticipated Social Security benefits without being considered discriminatory. RIPA would prohibit plans from eliminating pension benefits entirely through integration, and require that a minimal proportion of benefits be paid.

*Benefit and Contribution Limits.*—Tax qualified plans are limited in the amount of benefits they can provide any individual. In recent years, repeated reductions and lack of indexing in these limits has forced employers to set up non-tax-qualified plans for highly paid employees and reduced the funding of benefits for even rank-and-file workers. RIPA would revise these limits to create parity between defined benefit and defined contribution limits and to index the limits to the Social Security wage base to improve the stability of plan funding.

The purpose of this legislaton is to expand the proportion of the population receiving pension benefits and raise average benefits from employer-sponsored plans. Preliminary data prepared by ICF, Inc., for the Department of Health and Human Services in June 1985 showed that the combination of 5-year vesting and tighter distribution rules would increase future benefits paid to today's younger workers. The study simulated the pension income received by the families of workers who wil reach age 67 in the years 2011-2020. Earlier vesting and greater portability would raise average annual family pension income from $7,700 to $11,100 (1985 dollars) and would increase the percentage of families receiving pension income from 63 percent to 81 percent of families.

### (C) VESTING, INTEGRATION, AND PORTABILITY ACT OF 1985 (H.R. 2622)

The Pension Vesting, Integration and Portability Act of 1985 (H.R. 2622) was introduced in the House by Representative Kennelly on May 23, 1985. Identical provisions were included in the Economic Equity Act of 1985 (S. 1169) introduced by Senator Durenberger on May 20. The VIP legislation addresses some of the same benefit adequacy concerns addressed in the Retirement Income Policy Act. The bill would expand pension coverage by requiring private pension plans to cover part-time workers—with 500 to 1,000 hours a year—and workers within 5 years of the plan's normal retirement age. It would also lower minimum vesting standards to 5 years. VIP would require that small distributions be made to a portability account with the participant's approval, and would place a 100 percent excise tax on early distributions made to participations before age 59½. Plans that integrate with Social Security would be required to provide participants no less than the minimum pension benefit specified in the bill. Finally, the Secretary of Labor would be directed to study the feasibility of requiring private plans to provide cost-of-living adjustments.

### (D) SINGLE-EMPLOYER TERMINATION INSURANCE

After years of deliberation over reform of the PBGC's single-employer termination insurance program, in 1985, the Congress finally moved a bill reforming the program through most of the legislative process. By the end of the year, conferees from the House and Senate had met and agreed on a single bill increasing the premium for single-employer termination insurance from $2.60 to $8.50 per participant, and restructuring employer liabilities to the PBGC in the event of termination of an underfunded pension plan. Unfortunately, the single-employer legislation was part of the Comprehensive Omnibus Budget Reconciliation Act of 1985 [COBRA] which was not finally acted upon before the end of the first session, and remains as part of Congress' unfinished business for 1986.

Although similar legislation had been introduced in several previous Congresses, the premium increase and reform effort gained momentum in the 99th Congress largely through its association with deficit reduction and the budget reconciliation legislation. The tax-writing committees and labor committees in both chambers reported out provisions which went to conference as three separate bills: H.R. 3500—one of the House reconciliation bills containing the provisions of H.R. 2811 as reported by the Education and Labor Committee in September; H.R. 3128—the other House reconciliation bill reported by the Ways and Means Committee in October; and S. 1730—the Senate reconciliation bill containing the premium increase reported by the Finance Committee and the reform provisions reported by the Labor and Human Resources Committee. Of the three, H.R. 3500 contained the most carefully worked out reform bill, and the only one that had been the subject of hearings.

The single-employer termination insurance bill, as finally agreed upon by the Conferees, would raise the premium paid by employers from $2.60 to $8.50 per participant, and in return, tighten up considerably on the circumstances under which employers could terminate underfunded pension plans with limited liability to the PBGC. The bill would distinguish between "standard" terminations, where the employer was not in financial distress, and "distress" terminations where the employer was unlikely to have the assets to meet their obligations under the plan. In a standard termination, employers would have to pay all benefit commitments under the plan, including benefits in excess of the amounts guaranteed by the PBGC that were vested prior to termination of the plan. In a distress termination—where a company filed for bankruptcy, or would clearly go out of business unless the plan was terminated, or where the cost of the pension had become unreasonably burdensome—employers would be liable to the PBGC only up to 75 percent of the underfunding in the plan. In addition, employers in a distress termination would be liable for a portion of the amount of vested benefits in excess of the PBGC's guarantees—generally 75 percent of the amount owed, but not more than 15 percent of the plan's total benefit commitments. Employers would pay only 50 percent of the amount owed to either the PBGC or participants in years with no profits. In corporate transactions intended to avoid liability for an underfunded pension—within 5 years of termination—the company's controlled group at the time of the termination would remain liable.

This bill would substantially improve the PBGC's claim on company assets and prevent some of the "dumping" of unfunded liabilities on the PBGC. Although its future is at this time uncertain, it appears likely that some form of single-employer termination insurance legislation will be enacted in the 99th Congress.

### (E) PENSION REVERSION LEGISLATION

Three bills were introduced in 1985 aimed at blocking the termination of overfunded pension plans for the purpose of reclaiming surplus assets. In addition, Senator Metzenbaum succeeded in adding an amendment to the Consolidated Omnibus Budget Reconciliation Act (COBRA) that would, if reconcilation is enacted, delay the processing of asset reversion cases pending or filed before March 1. Finally, the tax reform bill—H.R. 3838—passed by the House in December contained a 15 percent excise tax on plan reversions.

Two of the three bills introduced in 1985 called for a 9-month moratorium on terminations of overfunded plans. S. 1532 introduced by Senator Metzenbaum and H.R. 3121 by Representative Roybal—both on July 30, 1985, would prohibit the Secretary of the Treasury from issuing a determination with respect to continuing qualification of a retirement plan and would prohibit the PBGC from issuing a notice of sufficiency for terminations involving a reversion of more than $1 million for a period of 9 months beginning June 12, 1985.

The third bill, the Plan Termination and Reversion Control Act of 1985, introduced on June 6 by Representative Roybal, would prevent employers from recovering the surplus assets through termination of a pension plan unless the termination was caused by a business necessity. Employers terminating a plan for other reasons would have to ratably distribute the plan assets to workers within 5 years of retirement and retirees. In all cases, a 10 percent excise tax would be imposed on assets recovered by the employer. Employers providing successor plans after a business necessity termination must provide comparable benefits in the successor plan.

Senator Metzenbaum succeeded in getting a shorter moratorium on terminations of overfunded plans included in the Reconciliation bill (COBRA). Reconciliation also included the requirement that the Secretary of Labor complete a study of plan asset reversions by February 1986. To date, the Department has convened a task force of the Advisory Council on ERISA to review the reversion issue and comment upon its effects on pension plan beneficiaries and recommend statutory changes.

An additional approach to responding to plan asset reversions is to place an excise tax on the reversion to recapture the tax advantages the employer had realized in building up the trust tax-free. The Treasury Department recommended in their November 1984 proposal to the President on tax reform that the Congress levy a 10 percent excise tax on reversions. The tax reform bill passed by the House in December included a 15 percent excise tax. This proposal is now before the Senate Finance Committee and will be considered in 1986.

This year also saw the first legal challenge to the PBGC's authority to withhold notices of sufficiency. The case centered around INTERCO, Inc., selling off most of the assets of its subsidiary P.N. Hirsch & Co., a junior department store chain, late in 1983. INTERCO engaged in a spinoff termination by transferring all Hirsch plan active participants into a new plan. This was done 12 days after INTERCO filed to terminate the Hirsch plan. The failure to vest the active participants and purchase annuities for their benefits eventually led the PBGC to reject the termination. Had the spinoff been approved, INTERCO could have reverted approximately $3.5 million from the $11.4 million plan. PBGC sought an extension of its 90-day statutory review period in August 1984. INTERCO refused and filed suit against PBGC, trying to force them to issue a notice of sufficiency.

Judge Nangle ruled that the PBGC has the authority to withhold notices of sufficiency in order to enforce ERISA. "If this court denied the PBGC the ability to order INTERCO to take certain steps to accomplish a valid spinoff, clearly the intent of Congress would be frustrated," he said.

There exists a possibility that the legality of the guidelines may be directly addressed in 1986 should a lawsuit challenging the United Air Lines pilot's plan spinoff/termination proceed to litigation. As of mid-February 1986, negotiations were continuing in an effort to avoid costly litigation.

### 4. PROGNOSIS

Many of the pension issues that commanded attention in 1985 remain unresolved at the end of the year. Legislation to raise PBGC premiums and reform the single-employer termination insurance has been approved by House and Senate conferees, but has been stalled by the failure of the Congress to take final action on the Comprehensive Omnibus Budget Reconciliation Act of 1985. The worsening financial condition of the single-employer insurance program, and the increasing probability that large under-funded pension plans will dump on the PBGC, makes the passage of reform legislation more important than ever before. Sometime during 1986, the Congress will have to consider passing either the full budget reconciliation bill, or acting separately on the pension reform provisions of the bill.

The pension changes proposed as part of the effort to reform the tax code will dominate the pension aganda in 1986. Tax reform will most likely be considered by the Senate Finance Committee sometime during the Spring of 1986. In the context of a massive effort to improve the fairness and simplicity of the tax code generally, the committee will have to focus on the issue of whether to adopt retirement income policy to improve the delivery of pension benefits, or whether to simply modify some pension features to making the distribution of tax benefits fairer. To the extent that tax reform does not address broader retirement policy concerns, there will be increasing congressional attention in the coming years to the problem of improving the delivery of pension benefits to lower and middle income and, particularly, to mobile workers.

In the more distant future the Congress may have to address growing concerns about pension funding. Terminations of defined benefit plans to recapture excess plan assets are on the rise, and several groups, including the Department of Labor, plan to issue recommendations for legislation in this area in 1986. In addition, there is increasing attention to the industry of pension fund managers that ERISA spawned and to the effect of investment practices on the adequacy of pension. These concerns could well prompt some congressional attention on pension investment in the coming years.

## B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

### 1. BACKGROUND

State and local pension plans were intentionally left outside the ambit of ERISA in 1974, despite the fact that many had and still suffer from financing difficulties due to large unfunded liabilities and offer less protection of participants' benefits than federally regulated private plans. Although some unions representing State and municipal employees have from the beginning supported the application of ERISA-like standards to these plans, opposition from local officials and interest groups have thus far successfully counteracted these efforts arguing that the extension of such standards would be an unwarranted—and unconstitutional—interference with the right of State and local governments to set the terms and conditions of employment for their workers.

State and local plans cover 11.4 million active and 3.1 million retired participants in more than 6,600 plans. Trust fund assets exceed $290 billion, and pay benefits amounting to $19.8 billion annually. Over 80 percent of these plans have fewer than 100 active members, but the largest 6 percent of plans cover about 95 percent of active membership. Nearly three-quarters of the State and local plans provide coverage under Social Security. Most do not integrate Social Security and pension benefits.

### 2. ISSUES

#### (A) FEDERAL REGULATION

The issue of Federal regulation of public pension plans has changed little in the past 10 years. At that time, Government retirement plans were exempted from the major provisions of ERISA to allow more time to determine whether Federal minimum standards were needed. In addition, states has argued that it would be contrary to the U.S. Constitution for the Federal Government to regulate the States in this manner. A joint task force by several congressional committees reporting on public employee retirement systems 4 years later in March 1978, concluded that State and local plans were often deficient in respect to funding, disclosure, and benefit adequacy.

The 1978 Task Force report found that Government retirement plans at all levels, but particularly smaller plans, were frequently not operated in accordance with generally accepted financial and accounting procedures applicable to private plans and other financial enterprises. There was a general lack of consistent standards of conduct, open opportunities for conflict-in-interest transactions, and frequent poor plan investment performance. Because many plans were not funded on the basis of sound actuarial principles and assumptions, potentially inadequate yearly contributions to fund future benefits put many participants at risk of losing benefits altogether. Lack of standardized and effective disclosure created a significant potential for abuse due to the lack of independent and external review of plan operations. Finally, although most plans effectively met ERISA minimum participation and benefit accrual standards, two of every three plans—covering 20 percent of plan participants—did not meet ERISA's minimum vesting standard.

It has become clear that there is variation and uncertainty in the interpretation and application of provisions pertaining to State and local retirement plans, including the antidiscrimination and tax qualification requirements of the Internal Revenue Code. While most administrators seem to follow the broad outlines of ERISA benefit standards, they are not required to do so. Recent studies suggest that the growth rate of public funds is outstripping the growth rate of private plans as public fund administators move aggressively to fund unfunded liabilities. The sheer size of the investment funds suggests that a dependable Federal standard would be prudent.

The need for improved standards has not obscured the latent constitutional question posed by Federal regulation, however. In *National League of Cities* v. *Usery,*[1] the U.S. Supreme Court held that extension of Federal wage and maximum hour standards to State and local employees was an unconstitutional interference with State sovereignty reserved under the 10th amendment. State and local governments have argued that any extension of ERISA standards would be subject to court challenge on similar grounds. The Supreme Court's decision in 1985 in *Garcia* v. *San Antonio Metropolitan Transit Authority,*[2] overruling *National League of Cities* has largely resolved this issue in favor of Federal regulation.

Perhaps in part because of the lingering question of constitutionality, the focus of Congress has been fixed on regulation of public pensions in respect to financial disclosure only. Some experts have testified that much of what is wrong with State and local pension plans could be cleared by the "fresh air" of disclosure.

### (B) SOCIAL INVESTMENT: SOUTH AFRICAN DIVESTMENT

State and local pension plans are vulnerable to local politics. At issue, this year as last, was the continued investment of pension assets in companies which do business in South Africa. About half of the Fortune 500 companies that are favorite blue chip investments for public and private plans fit this description. Action taken by State and local governments has ranged from full divestment of holdings in South Africa related banks or companies, to divestment of holdings only in companies which do not strongly adhere to the so-called "Sullivan Principles," or to "no new investment" policies. Some estimates have put total American investment in South Africa as high as $14 billion.

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[1] 426 U.S. 833 (1979)

[2] 83 L. Ed. 2d 1016, 53 U.S.L.W. 4135 (1985)

Generally speaking, pension trusts are subject to a prudent investment standard. Plan managers have an obligation to seek the best possible combination of risk and return, maximizing income for the sole benefit of trust beneficiaries. The issue is whether it is possible to meet this obligation while excluding many high-yield stocks from the pool of potential investments. A further complication which arises in the case of State and local plans. Here the fund is an instrumentality of the State or local government, and must be responsive to the citizens' desire to pursue particular social policy goals.

The passage of local initiatives to ban investment in South Africa raise serious questions in terms of the balancing of the fund's obligations to its participants and to the public. There is a strong argument that it might be prudent to divest African holdings before its economy deteriorates and would be sellers have no buyers. Yet, if a pension fund is forced to liquidate its portfolio at an inopportune time it could cost taxpayers millions of dollars in lost asset earnings. These shortfalls would have to be made up from general revenues.

### 3. LEGISLATION

#### (A) REPORTING AND DISCLOSURE; PEPPRA

As in the 98th Congress, the Public Employee Pension and Accountability Act [PEPPRA] was introduced in the House of Representatives, and in two bills on the same day; H.R. 3126, introduced by Representative Clay, and H.R. 3127, introduced by Representative Roukema. H.R. 3127 contains the same provisions as found in H.R. 3126, but includes an additional title amending the Internal Revenue Code to exempt State and local plans from certain present Code requirements. Neither bill has progressed past subcommittee consideration. Essentially the same legislation has been before the Congress since 1982.

PEPPRA would require disclosure and reporting of financial and other information to participants and their representative organizations, Government officials, taxpayers, and the general public. It establishes fiduciary standards for plan managers and trustees and provides appropriate civil remedies, sanctions, and access to Federal courts to participants and beneficiaries. H.R. 3127 would, in addition, clarify the application of the Internal Revenue Code to public plans and extend the tax benefits of qualified plan status to such plans and to their participants.

The reporting and disclosure provisions would require that participants be furnished a summary plan description written in a manner calculated to be understood by the average plan participant. The administrator of each public employee pension benefit plan would also be required to publish and make available an annual report providing financial data and information on the plan's funding policy. The financial statements would have to be audited by an independent qualified public accountant, and an actuarial valuation would have to be made a least once every 3 years. The Federal reporting and disclosure requirements would not apply in States where the Governor certifies that the law of the State sets substantially equal requirements.

Pension plan fiduciaries who exercise authority or control over the administration, management, or investment of plan assets would be required to carry out their functions solely in the interests of the participants and beneficiaries. Fiduciaries would be personally liable for any losses associated with a breach of fiduciary duty. They would be required to be bonded, follow a "prudent person rule," and diversify investments to minimize the risk of large losses. A fiduciary could not deal with plan assets for his own account or engage in certain transactions with a "party in interest" unless for "adequate consideration." However, the Secretary of Labor may grant an exception upon a finding that the party-in-interest transaction is administratively feasible and the interests of plan participants are protected.

The Secretary of Labor and the attorney general of a State would have investigative authority to determine whether any person has violated the law. An Advisory Council on Governmental Plans would be established, although with limited powers and resources, to monitor the implementation of the law and to submit a report of its findings and recommendations to the President and Congress.

### (B) DISINVESTMENT

On the local level, the movement for divestment picked up steam in 1985, partly in response to increased media and congressional attention to the public outcry against South Africa's apartheid policies. This year 9 additional States have enacted some kind of constraint on investments relating to South Africa, raising the total to 13. An additional 21 States have some legislation pending. Forty-one municipalities and 4 county governments have also limited investment, 33 in the past year. Advocates of divestment claim that restrictions now apply to State holdings worth at least $3.8 billion.

## 4. PROGNOSIS

Some observers have suggested that the sheer size of the public fund asset pool will lead to its inevitable regulation in the near future. Critics of this position generally believe that the diversity of plan design and regulation is necessary to meet divergent priorities of different localities and is the strength, not weakness, of what is collectively referred to as the State and local pension system. While State and local governments have consistently opposed Federal action, increased pressures to improve investment performance coupled with the call for responsible "social" investment may lessen some of the opposition of State and local plan administrators to some degree of Federal regulation. The current legislation's exemption from disclosure requirements for States with "substantially equivalent" disclosure statutes could be the key to melting opposition altogether.

## C. FEDERAL CIVIL SERVICE RETIREMENT

### 1. BACKGROUND

The Civil Service Retirement System (CSRS) is the staff retirement plan for more than 2.7 million Federal civilian employees, hired before January 1, 1984. In 1985, it paid benefits to 1.3 million retirees and 500,000 survivor annuitants. It is a management tool designed to attract and retain qualified personnel while providing a measure of financial security to employees who have completed their careers or are unable to perform their duties.

CSRS provides vested benefits after 5 years of service, equal to a percentage of the participant's high 3 years of pay. The percentage is determined by multiplying the retiree's years of service by a multiple of 1.5 percent for the first 5 years of service, 1.75 percent for the next 5 years, and 2 percent for all years of service thereafter. Participants are entitled to unreduced benefits at age 55, provided they have completed 30 years of service, and no later than age 62 so long as they have 5 years of service. Benefits have been fully indexed for increases in the Consumer Price Index (CPI) since 1962. Participants contribute roughly 7 percent of their salary toward CSRS.

The rapidly rising Federal deficit and concern over Federal personnel costs has led to a call for cuts in CSRS over the past decade, when rapid rises in the CPI drove up program costs. Inclusion of new Federal employees in Social Security subject to the Social Security Amendments of 1983 touched off a period of significant change for the CSRS. It created a need and an opportunity for the Congress to re-examine the overall structure of Federal employee compensation. Congressional committees charged with the task of designing a new pension plan initiated a lengthy study process, deferring the introduction of legislation until 1985.

### 2. ISSUES

#### (A) COST

Substantial criticism has been directed at the cost of the CSRS program. Total payments from the CSRS trust fund have tripled, in current dollars over the last decade. At the same time, the proportion of this cost paid by the Government has increased from 65 percent in 1975 to an estimate in excess of 80 percent in 1985.

The total employer cost of the CSRS is 25 percent of payroll, 5 to 8 percent more than the cost of a typical private sector plan, even including employer contributions to Social Security. The design of the CSRS includes a number of features which are costly relative to private sector plans. First, the system encourages early retirement of participants by providing unreduced benefits as early as age 55. Second, benefits have been fully indexed for inflation. Because Federal employee wages are more than 20 percent below those of comparable private sector employees and have not kept up with inflation, these features in combination have encouraged early retirement. Finally, the salary base for benefits is the average of the employee's high 3 years of compensation, a shorter averaging period than is prevalent in private sector plans.

In recent years, the most costly CSRS feature has been its method for adjusting benefits for inflation. According to a 1980 study, each 1 percent COLA increases long-term plan costs by 10 percent; as inflation increases, plan costs rise at ever-escalating rates. If inflation is 6 percent, a COLA will double the costs of CSRS over what it would be if none were paid. Private pension plans usually adjust pensions for the cost of living on an ad hoc basis, generally limited to 3 or 4 percent a year. The only retirement benefit most private employees receive that is fully indexed is Social Security. Likewise, full private pension and Social Security benefits are generally available only at age 65 and are actuarially reduced if taken at earlier ages.

### (B) ADEQUACY

While CSRS provides greater benefits for full career workers than a typical private pension plan, it provides relatively poor benefits to many more mobile civil service employees who leave before retirement. The Office of Personnel Management (OPM) estimates that 62 percent of all Federal employees participating in CSRS will receive no benefits. In all, two-thirds of benefits paid go to one-fourth of Federal employees. Employees must work 5 years to become vested and must work 10 years before the benefit formula begins crediting at full rates. Those who leave after vesting may choose to withdraw their own contributions instead of qualifying for benefits, but they lose the value of the Government's share. On the other hand, participants who leave their contributions draw benefits tied to their salary at the time they left Federal service, which can be quite low.

In addition, Federal retirees are potentially disadvantaged relative to other retirees by their lack of coverage under Social Security. Until recently, Federal employees have not been covered under Social Security during their tenure with the Government. Thus, they do not benefit from the portability of Social Security, nor its proportionately higher replacement rates for lower income participants. CSRS provides benefits based strictly on rate of pay and years of service.

Enactment of Social Security coverage for new employees in the Social Security Amendments of 1983 has lead to a redesign of the Federal retirement system. Social Security coverage for Federal employees had long been proposed by pension experts as a way to improve their retirement income while simultaneously improving the financial condition of the Social Security trust funds. The fundamental goal of policymakers has been to craft a retirement system which will encourage the growth of the type of Federal civilian workforce which best serves the Government's needs.

There are essentially two schools of thought as to the desirable workforce profile. Some argue that the American public is best served by a staff of experienced career employees. For these analysts the key issue in reform of the CSRS is to revise the incentives to retirees to retire as soon as they are eligible for benefits. While the deficiency in Federal wages is beyond the scope of CSRS reform, post-retirement COLA's and the immediate availability of unreduced benefits are often viewed as a starting point in removing incentives to retire early. A second group of critics argues that the Federal Government should attract more mobile workers from the private sector who do not plan on a full career of service in the Federal Government. In order to attract this type of worker, the Federal retirement system should allow greater portability of benefits.

### (C) MAJOR DESIGN OPTIONS

System design and system cost are two separate issues. Yet, given a desired system cost, numerous benefit structures can be designed to meet that cost. System cost is strictly a function of benefit generosity; the system design provides the structure through which those benefits are provided. Furthermore, within any benefit configuration, specific features can be designed so that the cost of any advantages could be spread over the entire participant population or could be structured as a trade-off: more of one benefit can be provided by scaling down the generosity of another, or a specific category of beneficiary can be made to bear the cost of special benefits received by that group.

Pension plans are divided into two basic types—defined benefit plans and defined contribution plans. A defined benefit plan has a definite formula for determining the amount of retirement benefit. A defined contribution plan, on the other hand, is essentially a savings plan that contributes an amount equal to a certain percentage of the employee's earnings each year. According to the Department of Labor, 69 percent of employees covered by pension plans are covered by defined benefit plans, but 72 percent of the plans are defined contribution plans. Most large employers provide defined benefit plans for their employees. The advantage of defined benefit plans to employees is the predictability of the benefit which will be received from the plan. The current CSRS is a defined benefit plan.

One issue in the design of the new Federal pension plan is the extent of employee involvement in paying for the cost of the plan. Civil Service employees currently contribute between 7 and 8 percent of their salary to CSRS, equal to about one-fifth the cost of the system when valued using assumptions that take into consideration future wage growth and inflation. Most private sector employees, on the other hand, do not contribute to their pension system. Should the new system be contributory or noncontributory, and if the former, what part of the total cost of the plan should be paid by employees?

In addition, whether to retain full automatic COLA's in the defined benefit component of the new Federal retirement system is an important question. Some analysts regard COLA protection as a bulwark against erosion of their benefits by inflation. However, this provision represents one of the single most costly features of the current design. Opponents of this provision argue that full inflation protection is rarely provided in the private sector. Since, like private sector employees, new Federal retirees will receive Social Security benefits which are indexed for inflation it has been suggested that partial COLA's, or COLA's for only certain classes of retirees (those over 65 or disabled) might be preferable in the new system.

Another design issue is how to coordinate Social Security benefits with the annuity provided by the Federal pension plan. Benefit adequacy is commonly measured in terms of the "replacement rate" provided by the annuity—that is, the ratio of the dollar value of retirement benefits to preretirement income. The President's Commission on Pension Policy estimated in 1981 that rates ranging between 51 to 86 percent would allow retirees to maintain their pre-retirement standard of living.

The current CSRS provides benefits purely on the basis of final salary, age, and years of service. It therefore provides the same gross replacement rates for retirees with similar service records. In conjunction with a progressive income tax, CSRS effectively provides higher net replacement rates to retirees with higher final wages.

On the other hand, Social Security is a social insurance program. It provides benefits to the insured worker or his dependents when the worker's income is interrupted by death, disability, or retirement. The program implicitly assumes that these circumstances cause economic need. Social Security also assumes that low-income families need a higher replacement rate than do upper income individuals, and Social Security benefits are substantially "tilted" toward individuals with low career wages.

There are three basic options for the new Federal retirement plan to recognize the redistributive aspects of Social Security. The new system can completely ignore, completely offset, or partially offset benefits from the retirement system for receipt of Social Security benefits. Both the first and second options create significant problems in terms of the system's manpower goals. If the new Federal retirement system were to ignore the receipt of benefits, then replacement rates for lower paid employees would be substantially higher than those for higher paid employees. Such a reduction could discourage many experienced personnel from serving in the Federal Government, particularly since salaries for upper level civil service jobs are already perceived as being lower than wages for comparable positions in the private sector. The second option of a total offset for receipt of Social Security has the virtue of equalizing the benefits to employes under the new and old Federal retirement system, but it flies in the face of the law for private retirement plans which may not offset 100 percent of the Social Security benefit. In addition, since a greater proportion of the lower paid civil service employee's retirement benefit would come from Social Security, it would greatly increase the portability of those benefits. Some analysts have suggested that this could cause higher turnover rates in the lower grades of the civil service.

The third option, a partial offset formula would best meet the goals of the present retirement system. It would preserve the twin advantages of Social Security's benefit tilt and portability to lower paid workers. For example, a 50-percent offset would result in a $1 reduction in CSRS benefits for each $2 in Social Security benefits. Under a retirement system using a 50-percent offset, lower income workers would have significantly higher replacement rates than similar workers covered by the current CSRS, and higher income workers would have correspondingly lower replacement rates than comparably paid workers covered by the current CSRS. Changes in retirement income would not be so large, however, as those resulting from ignoring receipt of Social Security benefits altogether.

The addition of a voluntary savings vehicle to the Federal retirement system, similar to the thrift and 401(k) plans in the private sector could ameliorate much of the impact of changes in the CSRS on higher paid employees, while still providing higher benefits to lower paid employees. A Voluntary Capital Accumulation [VCA] plan allows an employee to voluntarily contribute additional money to the retirement system. The incentive for making these extra contributions is the deferred payment of income tax on the contributions until retirement, when the employee's tax burden is usually lower. Often employers provide the additional incentive of a matching contribution for each $1 contributed by the employee. Because lower paid employees generally have less money for discretionary savings, date from the private sector indicates that they will participate at lower rates than higher paid employees. This projected difference in participation rates accounts for the different effects that VCAs are likely to have on the total retirement income replacement rates for lower and higher paid employees.

## 3. LEGISLATION

### (A) FISCAL YEAR 1986 BUDGET PROPOSAL

The Reagan administration once again proposed changes in civil service retirement to reduce its costs and "more closely align benefits for Federal retirees with those for the rest of the Nations's retirees." However, none of the administration's proposals for structural changes were enacted in large part because the Congress was nearing completion of its own redesign of the civil service retirement plan. There were eight major cost-cutting proposals:

—No COLA in fiscal year 1986.

—All future COLA's to be based on the lower of the CPI or the General Schedule salary increase.

—Annuity values above $10,000 would be adjusted by 55 percent of the COLA.

—Benefits received before age 65 would be reduced by 5 percent for each year.

—Base the benefit on the highest five years of salary, rather than highest 3.

—Service credit at retirement would no longer be given for unused sick leave.

—Certain survivor benefits would be eliminated or restricted to the eligibility criteria of Social Security.

—Payment to the CSRS trust fund would be increased for the Postal Service and for the District of Columbia Government.

The administration projected savings of $786 million in fiscal year 1986, largely a result of the COLA freeze.

In its First Concurrent Budget Resolution (S. Con. Res. 32), the Senate Budget Committee proposed to place a 1-year freeze on COLA's, limit post-1986 COLA's to the CPI minus 2 percent, increase the employee contribution to 9 percent in 1987, and accepted the administration's proposal regarding Postal Service and District of Columbia payments. Overall savings from these provisions was estimated at $361 million. The full Senate accepted the COLA freeze, increased contribution, and Postal Service payment provisions. It also added in the change in survivor benefits, as proposed by the administration and mandated another $2 to $3 billion in other unspecified savings to be determined by the Governmental Affairs Committee. However, the House and Senate agreed to drop the Senate's changes for CSRS, leaving the CSRS unaffected by the budget resolution which was finally passed on August 1.

### (B) THE GRAMM-RUDMAN-HOLLINGS ACT (PUBLIC LAW 99-177)

Civil Service Retirement COLA's were eliminated in fiscal year 1986, however, under the provisions of the Balanced Budget and Emergency Deficit Control Act, commonly known as Gramm-Rudman. Gramm-Rudman created two categories of programs which receive automatic COLA's; those for which COLA's would automatically be suspended in the event the Government failed to meet its deficit reduction targets, and those which would be exempt from cuts. The CSRS (as well as the military retirement plan) was not exempted, and Gramm-Rudman further called for an immediate suspension of the 3.1 percent COLA scheduled for both civilian and military retirees in January of 1986. For an average civil service retiree receiving a monthly benefit of $1,119, this results in a loss of $34 per month. The total savings in fiscal year 1986 to the Federal Government because of the cancellation of the COLA for civil service retirees is $536.7 million.

For fiscal years 1987 to 1991, COLA's that would otherwise be payable in nonexempt programs after the first day of the fiscal year will be suspended until the effective date of the President's final order (October 15). They would be permanently cancelled for the fiscal year unless the order specifies that the budget targets will be met for that year without reducing or canceling them. Gramm-Rudman specifies that automatic spending increases be suspended as the first step toward budget reduction, to be followed by reductions in other programs as needed to meet the budget target levels. No more than 50 percent of the target reduction can be achieved through the suspension or reduction of COLA's. Some analyses have suggested that if Gramm-Rudman continues to operate through 1991 to cancel retirees' COLA's, the purchase power of their benefits will be reduced by nearly one-quarter of their present value.

### (C) REDESIGN: THE FEDERAL RETIREMENT SYSTEM [FRS]

Differing resolution of key plan design issues such as mobility of the workforce and portability of benefits, age of retirement, and indexing of benefits has culminated in two distinct alternatives by the separate Houses. Although the transitional plan for employees hired after January 1, 1984, was due to expire on January 1, 1986, the Conference Committee was unable to resolve the differences between the two bills prior to the end of the session. The Congress extended the deadline to April 1986 for enacting a replacement plan for Federal workers hired after January 1, 1984.

While interest in reducing the cost of Federal retirement through the new plan has receded somewhat, cost remains a key difference between the Senate and House proposals. While the Senate bill, S. 1527 reduces the cost of the program to 21.9 percent of payroll, by most estimates the House proposal, H.R. 3660, keeps cost the same, or increases them slightly to 25.4 percent of payroll. None-the-less, the basic design of both bills is the similar. They would combine Social Security, a defined benefit plan, and a voluntary capital accumulation (VCA) plan. In both proposals, full participation in the VCA is necessary to raise retirement benefits to or above current law levels.

### *(1) The Senate Bill: S. 1527*

The Senate FRS proposal, by comparison with the House proposal, makes more significant changes in the design of the basic defined benefit plan. In recognition of the diversity and size of the Federal workforce, S. 1527 offers two different retirement plans. Employees must elect which plan they wish to participate within 60 days of beginning Federal service. Certain changes pertain to both options. The base pay upon which accruals are based is the average of the employee's highest 5 years of compensation. The COLA provisions are less generous than those under current law.

In Option A, the basic annuity is fully paid for by the Government and provides an annual accrual rate of 0.9 percent per year of service for the first 15 years of service, and 1.1 percent for the remainder. Unreduced benefits are available at age 62. Benefits are also available at age 55 with 30 years of service, but are subject to a 2 percent reduction for each year under 62. An employee's defined benefit is adjusted annually for inflation, after retirement beginning at age 62. The annual adjustment is equal to the increase in the CPI minus 2 points from age 62 to age 67, and 100 percent of the CPI at age 67 and above. Finally, Option A includes a VCA in which the Government matches dollar for dollar, the first 5 percent of an employee's salary contributions. The employee may contribute an additional 5 percent of his salary tax-free.

Option B requires employees to contribute to the defined benefit plan the difference between the normal CSRS contribution (7 percent) and the OASDI tax. This means that employees contribute 7 percent on any salary in excess of the Social Security wage base, but only a nominal amount on salary up to the wage base (1.3 percent in 1986). The match on the VCA plan is different from Option A in that the first 1 percent of salary is matched dollar for dollar, percentage points 2 and 3 are matched at 50 cents on a dollar, and percentage points 4 through 6 are matched at 25 cents on a dollar. In turn, an employee can retire at age 55 with 30 years of service with unreduced benefits from the defined benefit plan. Post-retirement inflation protection on the defined benefit plan is CPI minus 2 points for retirement under age 62, with a COLA equal to the increase in the CPI beginning at age 62 and above.

In essence, S. 1527 provides a degree of career flexibility to Federal workers not currently available under the CSRS. Option A contains more flexibility and portability than Option B through a richer VCA plan. Option B contains more security with a richer, inflation-protected defined-benefit plan. Both options "back-load" accurals under the defined-benefit plan, substantially favoring full-career employees.

### *(2) The House Bill: H.R. 3660*

For the average employee retiring after a full career with the Government, the combined benefits provided under this proposal are similar to the benefits of the CSRS. However, because of the distribution of Social Security benefits, lower paid employees receive somewhat more than under the CSRS, and higher paid employees, somewhat less.

In general, the FRS defined benefit component provides retirement benefits of 1 percent of high-three average salary for each year of service for most Federal employees. The House would continue to make retirees eligible for full retirement benefits at age 55 with 30 years of service, age 60 with 20 years of service, or age 62 with 5 years of service. In addition, it would provide a supplement to employees retiring before they are eligible to receive Social Security. Benefits would be fully indexed for inflation. At a cost of approximately 10 percent of the employee's projected annuity, the FRS would provide survivor benefits to spouses of deceased employees equal to 50 percent of their earned annuity, and would provide supplemental benefits to survivors who do not receive benefits from Social Security. The employee must contribute 7 percent of his salary, minus the percentage he contributes for OASDI (currently 5.7 percent), to the FRS. The VCA plan suggested by the House version would match the employee's savings 50 cents for every dollar contributed up to 6 percent of salary. It would allow the employee to contribute another 4 percent tax-free.

### 4. PROGNOSIS

Passage of a final package appears inevitable in early 1986. The House and Senate bills are very similar, yet Gramm-Rudman has created a climate in which cost factors are likely to play a larger role than previously anticipated. Resolution of the differences between the House and Senate versions of the new Federal retirement system also seems dependent in part on the shape of retirement income proposals being considered as part of tax reform. There has been a perceptable push, particularly from the administration, to redesign the Federal system to more closely resemble the best of private sector plans. Both the House and Senate bills largely accomplish this goal, but at substantially higher percentages of payroll than the administration has set as its goal. It remains to be seen how many of the myriad of objectives of redesign can be accomplished.

## D. MILITARY RETIREMENT

### 1. BACKGROUND

The military retirement system has remained almost entirely intact since World War II due to a vocal and effective lobby of participants and those who administer the program. Three types of benefits are provided under the system: Standard retirement benefits, disability retirement benefits, and survivor benefits under the

Survivor Benefit Program (SBP). With the exception of the SBP, all benefits are paid by contributions from the employing branch of the armed service, without contributions by the participants. A participant's retirement benefit is based on a percentage of his high 3 years of basic pay, determined by multiplying years of service by a multiple of 2.5. In no case does a retiree receive more than 75 percent of basic pay in retirement and since no vesting occurs until after 20 years of service, a retiree receives a minimum of 50 percent of basic pay. The benefit is payable immediately upon retirement from military service, regardless of age and without taking into account other sources of income which the retiree may earn or receive from other sources. By statute all benefits are fully indexed for changes in the Consumer Price Index (CPI).

## 2. ISSUES

The military retirement system has been highlighted by numerous commissions and the media as an unnecessarily expensive retirement program. Escalating costs are compounded by the public perception that the military retirement program provides benefits that are too generous at too early an age. Most participants are eligible to and to retire in their early 40's and 50's, with a benefit equal to half of their basic pay.

The temptation to compare military pensions to those found in the private sector solely on the basis of economic factors is difficult to avoid, especially absent any immediate threat of war. The pivotal issue, in evaluating the military retirement system however, is not cost, but the goals of the system. Despite general agreement among military manpower analysts, the office of the Secretary of Defense, and nonmilitary observers concerning the need for major structural change in military retirement, recent analyses have not adequately reflected a change in the basic manpower model which was in place when the military retirement system was developed in the years following World War II.

Approximately 1.5 million retired officers, enlisted personnel, and the beneficiaries will receive nearly $18.4 billion in annuity payments in 1986. At current rates of growth, this expenditure is expected to reach $45 billion annually by the end of the century.

### (A) COST

Since 1969, 10 separate studies have recommended changes to reduce the system's cost, but no comprehensive legislation has resulted. In particular, four identifiable features of the military retirement system greatly contribute to its cost. First, full benefits begin immediately upon retirement—sometimes as early as age 38 or 40, and continue until the death of the participant. Second, military retirement benefits are fully indexed for inflation, although COLA's have recently been delayed on several occasions when they were also delayed for other Federal retirees. Third, the system is basically non-contributory, although in order to provide survivor protection, the participant must make some contribution. Finally, military retirement benefits are not integrated with Social Security benefits.

Supporters of the current military retirement scheme have identified several characteristics arguably unique to military life which they feel justify relatively more liberal benefits to military retirees than other Federal retirees. All retired personnel are subject to involuntary recall in the event of a national emergency; retirement pay is ostensibly part compensation for this exigency. Military service has been seen to place special demands on military personnel, including higher levels of stress and danger, and more frequent separation from family, than civilian service. Finally, the current benefit structure provides a significant incentive for older personnel to leave the service in order to maintain "youth and vigor" in the armed services. In this respect it has been largely successful. Almost 90 percent of military retirees are under age 65, 50 percent under the age of 50. The average aggregate benefits which a retiree in 1985 received from the military retirement system was $1,103.

Military retirement is fully indexed for inflation, a feature which retirees have traditionally considered central to the adequacy of retirement benefits. It has also been the object of most deficit reduction measures in recent years along with the COLA for other Federal retirees.

Military personnel do not contribute to their retirement benefits, though they do pay Social Security taxes and offset a certain amount of their pay to participate in the Survivor Benefit Program. Only a small minority of the studies conducted in the past decade have recommended contributions by individuals. This has two consequences. For employees, they have no employee contributions to take with them if they leave before vesting in a retirement benefit, as do Federal employees for example. For taxpayers, a small but significant source of revenue to fund the program is foregone.

Finally, since the institution of Social Security coverage for military personnel in 1956, military retirement benefits have been paid without any offset for Social Security. Taking into account the frequency with which military personnel in their middle forties retire after 20 years of service, it is not unusual to find them retiring from a second career with a pension from their private employment, along with their military retirement, and a full Social Security benefit. This has resulted in some former armed services personnel receiving as much as 90 percent of their basic pay. Failure to integrate military retirement benefits with Social Security generally adds to the perception that it is an overly generous system.

### (B) RETIREMENT ADEQUACY

The debate over military retirement has not focused merely on the enormous cost of this system, but as well on the system's adequacy at providing retirement income to those men and women who serve in the Armed Forces. Several recent studies of the military retirement system have suggested that the 20-year service requirement is unfair to the majority of military personnel. Nearly 65 percent of officers and 90 percent of enlisted personnel leave before completing the requisite 20 years of service. It has been suggested that this design is likely to prolong the careers of marginal military personnel beyond their usefulness, while simultaneously providing an incentive for highly skilled and experienced personnel to leave the Armed Forces for second careers as soon as they complete 20 years of service, in order to capitalize on private sector employment opportunities—and pensions. In the end, the result is a system which pays relatively high benefits to a disproportionately high number of officers when compared to the composition of the military as a whole.

Commentators have periodically called for shorter vesting schedules, comparable to those required for private plans under ERISA, or for other Federal service jobs. Some military manpower experts have argued that such a change would adversely impact the ability to maintain "youth and vigor" in the military workforce. On the other hand, some military manpower analysts argue that the need for youth and vigor is overstated in view of new technologies which put a premium on technical skills rather than physical endurance.

## 3. Legislation

### (A) THE DEFENSE AUTHORIZATION ACT (PUBLIC LAW 99-145)

As in previous years, the cost of the military retirement system has driven debate over substantive reform. Despite the attention given to the year old Fifth Quadrennial Review of Military Compensation, legislators in both Houses declined to engage in an overhaul of the system. Instead, the Congress opted for a provision on the Defense Authorization Act which mandated a $2.9 billion reduction in the total expenditure for military compensation and retirement.

Initially, the Senate called for a 10 percent reduction or a $1.8 billion reduction in the accrual charge—the annual contribution by the defense Department—via structural changes in the program which would be applicable to new entrants only. It also called for a report by the Department of Defense on the impact of changes in retirement, compensation, or personnel programs that would be necessary to achieve savings equal to a 20 percent and a 30 percent reduction in the accrual charge.

The House amendment contained provisions directing the Secretary of Defense to reduce the accrual charge for nondisability retirement by $4 billion—a reduction of 22 percent—in fiscal year 1986. The House would also apply these structural changes only to new entrants. House language stressed its desire that these changes should encourage longer service. The Secretary would be required to submit a separate report on a transition plan.

In conference, the House and Senate agreed to a ceiling on the total of basic pay and accrual charge that requires a $2.9 billion reduction in the accrual charge for the military retirement system, without affecting the benefit of those currently retired or serving in the armed services. The Secretary of Defense must submit a report and draft legislation proposing two separate changes. One of these proposals must not include changes in the COLA's in retired pay, and each must be sufficient to reach the target reduction. The Defense Authorization Act also requires that the Secretary submit a report describing the changes necessary in retirement, compensation, or personnel programs and the impact of such changes on recruiting and retention that would be necessary to achieve savings equal to $1.8, $2.9, $3,6, $4, and $5.4 billion in accruals for retirement.

Owing to a delay in the passage of the Defense Authorization Act, the Secretary of Defense was delayed in formally submitting the required proposals, however, the proposals have been available informally. As Congress mandated, under Proposal I military retirees would continue to receive COLA's based on the full annual increase in the Consumer Price Index (CPI). Service members would continue to be eligible for retirement with an immediately payable monthly annuity after 20 years of service. However, their retired pay would be computed as a percentage of the average of their highest 5 years of basic pay, rather than their highest 3 years (effective for those joining the service after September 7, 1980). In addition, under this alternative, retired pay would be computed on the basis of 2.15 percent of basic pay for each year of service through 20, and 3.2 percent for each year of service between 20 and 30. A 20-year retiree would therefore receive 43 percent of high 5 basic pay, a 25-year retiree, 59 percent. A 30-year retiree would continue to receive 75 percent of basic pay, although based on a potentially lower, high 5 computation base.

Proposal II does include a cut in COLA's. Military retirees would receive COLA's based on the annual rise in the CPI minus 1 percent. When the retiree reached the 40th anniversary of his entry into military service, his retired pay would be recomputed on a one-shot basis to restore the purchasing power it had at the time of his initial retirement. Thereafter, COLA's would continue to be based on the annual CPI minus 1 percent. This alternative also proposes a two-tier accrual percentage—2.2 percent for each year of service through 20, and 3.1 percent for each year thereafter up to a maximum of 30 years. This results in a 20-year retiree receiving 44 percent of his basic pay, a 25-year retiree receiving 59.5 percent of his basic pay, and a 30-year retiree, 75 percent of basic pay.

It is difficult to predict which alternative will have appeal to Congress. Traditionally, the Congress has been more inclined to change COLA protection than more fundamental aspects of the military retirement compensation formula. Yet some analysts observe that, particularly among younger retirees, full inflation protection of retirement benefits is extremely important, leading to speculation that participants might be willing to accept the relatively lower initial levels of retired pay resulting from implementation of a high five computation base in order to retain full COLA's.

In any case, it is important to note that neither proposal contemplates reducing the 20 year service requirement for vesting a pension benefit, although both packages would theoretically encourage longer service by raising the multiple for years of service after 20. Nevertheless, the large numbers of personnel who leave prior to 20 years of service would be left with no retirement income protection other than Social Security.

#### (B) GRAMM-RUDMAN-HOLLINGS

As in the case of the CSRS, Gramm-Rudman did not exempt the military retirement system. Military retirees scheduled to receive an average COLA in January 1986 of $34 per month, did not receive that increase. To the extent that the Congress and President fail to meet budget targets set in Gramm-Rudman, it is possible that military retirees and their beneficiaries will not receive COLA's through fiscal year 1991.

### 4. PROGNOSIS

To the extent that it deals with military retirement, the Congress will be consumed with considerations of the two cost-cutting models submitted for its consideration by the Secretary of Defense. It is important to note that although the Congress has not yet considered the proposals mandated by the Defense Authorization Act, its budget appropriation presumes a $2.9 billion reduction in expenditures for fiscal year 1986 which the military retirement plan will have to absorb in one fashion or another whether the Congress acts on the Department of Defense's proposal or not. Following the relative flurry of activity in military retirement this year, it is unlikely that 1986 will bring any real action toward a substantive redesign of the military retirement system. Even with the submission of the studies as demanded by the Defense Authorization Act of 1986, any reform in the military retirement system must overcome the well-organized opposition of constituencies which traditionally do not favor change.

## E. RAILROAD RETIREMENT SYSTEM

### 1. BACKGROUND

The Railroad Retirement system is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with the Social Security system. The system was established in 1935, prior to the creation of Social Security, and it remains the only federally administered pension program for a private industry. It covers hundreds of railroad firms and distributes retirement and disability benefits to employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of dual vested or so-called "windfall" benefits, which are paid for through Federal general revenues from a special account. Currently, just under 1 million retirees receive Railroad Retirement benefits, and total payments to these beneficiaries reached almost $6 billion in fiscal year 1985. Rail employment, which determines the financial status of the Railroad Retirement system through payroll tax revenues, has now stabilized at level hovering around 400,000, after dropping precipitously in 1981, 1982, and early 1983.

## 2. Issues

### (A) THE STRUCTURE OF THE RAILROAD RETIREMENT SYSTEM

The broadest policy issue associated with the railroad retirement system is simply: Do we still need an independent, publicly administered railroad pension system? The general structure of the railroad retirement system results from its unique development. In order to understand the major issues facing the railroad retirement system, it is critical to review this development. In the final quarter of the 19th century, railroad companies were among the largest in America, and were marked by a high degree of organizational centralization and integration. The original railroad retirement system was created in 1934 to provide annuities to retirees based on rail earnings and length of service.

The Railroad Retirement Act of 1974 fundamentally reorganized the railroad retirement system, and established the outline of its present day organization. Most significantly, the legislation created a two-tier benefit structure in which tier I serves as an equivalent to Social Security, and tier II parallels a private pension. Tier I benefits are computed on credits earned in both rail and nonrail work, while tier II is based solely on railroad employment. The total benefit amounts to traditional railroad annuities, and eliminates duplicate coverage for nonrail service by both Social Security and the railroad retirement system. In its fiscal year 1983 budget, the Reagan administration proposed dismantling the system, with Social Security absorbing tier I, and tier II being converted into a private pension, administered by a private corporation. This proposal was founded on the assumption that the Government should not administer an industry pension, and that given the equivalency of tier I and Social Security, it is appropriate to combine the two, and create a privately administered pension to complement it, as is the case with other industries.

This proposal was rejected by Congress. Many felt that reorganization would lead to a cut in benefits for present and future retirees, and that if exempted from ERISA standards, as proposed by the administration, employees and retirees would have no guarantee that their full pensions would be provided. It was further argued that such a conversion would exacerbate Social Security's financing problems, and create administrative difficulties for SSA, similar to the creation of SSI, and SSA's assumption of the black lung program.

In 1985, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Congress considered a proposal to increase taxes on railroad retirement benefits. The tax treatment of tier I benefits was similar to that of Social Security: Half of tier I benefits are taxed to the extent that, combined with other income, they exceed a threshold amount ($25,000 for individuals and $32,000 for couples). Tier II benefits are taxed as private pension benefits.

The change in the tax treatment included in reconciliation is consistent with the effort to treat tier I exactly like Social Security. The provision would tax that aspect of the tier I benefit more generous than Social Security as tier II benefits are taxed. Under the Treasury proposal, tier I benefits would be divided into two components, tier I-A and tier I-B. Tier I-A is the amount that is identical to benefits which the worker would have earned under Social Security had his entire career been in nonrail employment, and an amount of extra benefits which result from the rail system's unique qualification rules. One of these unique rules allows workers to retire at 60 if they have 30 years of rail employment. Another rule allows workers to qualify for disability payments under standards that are less stringent than those for Social Security Disability Insurance. Treasury estimated that taxation of non-Social Security parts of tier I benefits would produce $160 million annually.

Critics of the tax proposal argued against it on several grounds. First, they believed that the new tax followed too closely on the heels of other recent taxes on and cuts in the retirement program. Second, the complexity of the plan to create further sub-categories in benefits would create difficulties for recipients and for the Railroad Retirement Board. Third, despite being labeled a tax measure, the proposal amounted to a benefit cut for people on fixed incomes who had already made retirement plans based on earlier payment levels. Fourth, the proposal was not considered in the context of tax reform legislation, which would have clarified its impact on tax and retirement policy.

### (B) RECENT FINANCING PROBLEMS

During the 1970's the rail industry performed poorly, and by 1980, the retirement trust fund was faced with the prospect of insolvency. Declining rail traffic, and hence declining employment, led to diminished payroll tax revenues. Since the end of World War II, the worker/beneficiary ratio has been decreasing, as described by the table below:

EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945

[In thousands]

| Year | Average employment | Beneficiaries |
|---|---|---|
| 1945 | 1,689 | 210 |
| 1950 | 1,421 | 461 |
| 1955 | 1,239 | 704 |
| 1960 | 909 | 883 |
| 1965 | 753 | 930 |
| 1970 | 640 | 1,052 |
| 1975 | 548 | 1,094 |
| 1976 | 540 | 1,100 |
| 1977 | 545 | 1,107 |
| 1978 | 542 | 1,100 |
| 1979 | 554 | 1,093 |
| 1980 | 532 | 1,084 |
| 1981 | 503 | 999 |
| 1982 | 440 | 988 |
| 1983 | 390 | 981 |
| 1984 | 400 | 980 |
| 1985 | 374 | 954 |

Source: Railroad Retirement Board, 1986.

This longer term financing problem grew worse because congressional appropriations for "windfall" benefits were far from sufficient to pay for those benefits, and the difference was paid from the Railroad Retirement trust fund.

To improve the system's financial condition, Congress included railroad retirement provisions in both the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) and the Economic Recovery Tax Act of 1981 (Public Law 97-34). These amendments raised payroll taxes on employers and employees, modified benefits, created a separate account for windfall benefits, and provided the railroad retirement trust fund with authority to borrow funds from the General Treasury, when near term cash flow difficulties arise.

Unfortunately, the recession devastated the railroad industry in the final quarter of 1982, bringing the railroad retirement system once again to the brink of insolvency.

Early in 1983, rail labor and management collectively negotiated a comprehensive financing package and submitted it to Congress. This agreement was considered by Congress, revised, and ultimately enacted in August 1983. The final package was composed of payroll tax increases, benefit reductions, and Federal contributions. Passage averted a 40-percent reduction in tier II benefits scheduled for October 1, 1983.

Key provisions of the Railroad Retirement Solvency Act of 1983 (Public Law 98-76) included the following:

(1) A COLA offset provision, which required that the next 5 percent of tier 1—Social Security—COLA increases be subtracted, dollar for dollar, from tier II—railroad pension—benefits. This completely eliminated the 3.5 percent COLA scheduled for January 1984, and reduced the 1985 COLA from 3.5 percent to 2 percent. Justification for the COLA reduction came from the belief that the burden of producing solvency for the system should fall on management, labor, and retirees—management and labor through increased taxes, and retirees through reduced benefits. Better than expected economic performance of the rail industry since enactment of the 1983 changes however, produced a corresponding improvement in the retirement funds. The improved health of the funds has led to calls for a cancellation of the final 1 and a half percent COLA cut imposed on retirees.

(2) The so-called 60/30 benefit, which allows employees with 30 years of service to retire at age 60 without benefit reduction, was scheduled to be phased out.

(3) Three annual 0.75 percent payroll tax increases (the first went into effect in January 1984) were to be levied on rail employees and employers.

(4) The wage base on which the employer-paid railroad unemployment insurance tax paid by employers is levied was increased by 50 percent from the first $400 of monthly earnings to the first $600 of monthly earnings. A temporary unemployment tax is to be collected from employers on July 1, 1986, to repay a debt owed by the unemployment account to the retirement fund.

(5) Tier II benefits and vested dual or windfall benefits were made subject to Federal income taxation under the same

guidelines as private pension benefits—i.e., to the extent that pension benefits exceed the employee's contributions. The revenues collected from this taxation will be transfered to the rail trust fund to finance benefits payments, through 1989. After that point, the revenues will remain with the Federal Treasury.

Overall, the Railroad Retirement Solvency Act of 1983, through a combination of tax increases, benefit adjustments, and Federal assistance is expected to maintain the solvency of the railroad retirement system through the 1990's, even under pessimistic employment assumptions. Further, it is expected that in the future, the worker/retiree ratio will increase, as the peak in number of retirees passed.

The legislation is not without its critics though, and it is important to point out some of the weaknesses in the law. For instance, the COLA offset provision could not be accomplished if the tier II benefit component were truly were an industry pension, and subject to ERISA regulations. To take funds from tier II to offset increases in tier I benefits partially undermines the basic assumption of the 1974 reorganization. The abrupt phase-out of 60/30 benefits jeopardizes the plans of older rail employees who had conceived their retirement on benefit assumptions that have been rendered invalid. To rapidly change the rules in mid-stream is inequitable to employees nearing retirement. Finally the tax treatment of windfall benefits as equivalent to pension benefits is inconsistent with the fact that windfall payments accrue from Social Security coverage. Windfall benefits should be taxed like Social Security benefits, not like returns from a private pension.

### (C) TAXATION OF BENEFITS

The railroad retirement system contains numerous unique benefit qualification rules which distinguish tier I benefits from those provided by Social Security, and which distinguish tier II from most private pension systems. Since railroad retirement takes the place of these systems, the presence of the unique rules has led critics to call for their removal.

One frequently criticized rule is the "last person service" requirement for tier II benefits. This rule requires that a worker leave his current employment before he can collect benefits, regardless of whether his current employment is in the rail industry. Private pensions require that workers leave current covered employment before receiving their pensions, but they do not require that workers leave current employment which is unrelated to their covered employment.

Other criticized rules which do not comport with Social Security or private pension practice include limits on the eligibility of divorced spouses for benefits, inadequate credit for periods of military service, and no allowance for trial work periods before annuities are reduced.

### (D) SOLVENCY OF THE RAILROAD UNEMPLOYMENT INSURANCE SYSTEM

The RUI system is insolvent, and has borrowed money to pay benefits from the retirement system for 20 of the last 25 years. In the past, these loans were used to bridge short-term cash flow problems in the RUI program, and were repaid with interest. However, drastic increases in rail unemployment in the past few years have led to more protracted and more extensive borrowing from the retirement fund. By July 1984, the RUI system owed more than $700 million to the retirement account. It is expected this debt will reach $1 billion in fiscal year 1986. Without major changes in the financing of the RUI system, it is unlikely that this debt could ever be serviced.

The 1983 Retirement Solvency Act created a Railroad Unemployment Compensation (RUC) Committee to study the RUI problem and make recommendations to Congress to either restore solvency to the RUI system or to fold it into the Federal-State unemployment compensation system.

The RUC panel presented two alternative proposals in its June 29 report. A majority of this panel, consisting of the two labor members and the chairman, recommended keeping a separate rail unemployment insurance system. The two management members advocated a transfer of the RUI system to the States, and provided a proposal to accomplish this in a fashion acceptable to rail companies. The management representatives joined the majority in shaping a "consensus" package of specific recommendations for saving the RUI system. Management pledged its support to the consensus package in the event that Congress rejected the management proposal.

Under the consensus package, a separate RUI system would be retained and solvency would be restored through a number of financing changes. From the standpoint of retirement fund, the most critical provision in the consensus proposal is a waiver of all interest on principal owed by the RUI account from past loans. Waiving the interest on $1 billion of debt, which would be paid over a period extending to the year 2000, would represent a serious financial sacrifice by the retirement account to the unemployment system. This provision pits the interests of younger employees, faced with prospect of continued spells of high unemployment, against the concerns of retirees.

The principal on the RUI loans would be repaid through a flat-rate tax, subject to periodic adjustment, imposed on railroad companies. Additionally, a variable employer-paid surcharge tax would be levied, and experience rating would be thereby introduced to the RUI system. Rates would vary depending upon the balance in the RUI account. General revenues would contribute to the rescue of the RUI system through a one-time grant of $135 million to compensate for past interest paid on loans from the retirement fund while the Federal-State programs were receiving interest-free loans from the Federal Government. Further, the RUI account would be provided with the authority to borrow from the Treasury to avoid near-term cash-flow problems. Finally, the consensus proposal recommends certain tax and benefit modifications to improve the financial health of the RUI system.

The management proposal recommended a transfer of the RUI system to the States at the beginning of the first benefit year (which begins July 1) feasible after enactment. Rail carriers would begin paying State unemployment taxes, and in addition, a surcharge tax would be levied to pay back the principal on the debt owed to the retirement fund, but not the interest. Sickness benefits, an important feature of the RUI system, would be established as a separate program administered by the RRB and financed through a small tax on carriers. The Federal Government under this plan would transfer $200 million to the retirement account to compensate for interest paid on loans while States were receiving interest-free loans. General revenue funds would also be provided to States to help with the transition between the two systems, when unemployed rail workers would be receiving benefits that would be partially based on untaxed compensation.

Independent of the RUC committee, the Reagan administration has proposed its own legislative package that would tranfer the RUI system to the State unemployment compensation programs. This plan would have required newly unemployed rail workers to begin filing for State benefits on January 1, 1986; continuing RUI beneficiaries would have had their claims converted by June 30, 1986. Railroad employers would reimburse the States for all benefits paid to rail workers between January 1, 1985, and June 30, 1986. The RUI system would be allowed to continue to borrow from the retirement fund until June 30, 1986, and the debt to the retirement system would be serviced through the special unemployment surtax mandated by the 1983 solvency legislation.

As a matter of railroad retirement policy, the critical issue is how will the enormous debt owed by the RUI system be paid, and more specifically, will the retirement account recoup the interest owed on that debt over time.

## 3. LEGISLATION

### (A) RAILROAD UNEMPLOYMENT LEGISLATION

In 1985, attention turned to solving financial problems in the rail unemployment system. Following the passage of the Railroad Retirement Solvency Act of 1983 (Public Law 98-76), which restored short- and long-term solvency to the railroad retirement system through a combination of tax increases, benefit reductions, and Federal financing, there was little interest in railroad retirement changes.

The one major subject left unresolved by the comprehensive legislation package enacted in 1983 was the insolvency of the Railroad Unemployment Insurance (RUI) Program. The 1983 legislation did establish a Railroad Unemployment Compensation (RUC) Committee, composed of representatives of rail labor, management, and the general public, to examine the condition of the RUI program, and make recommendations to Congress to redress the system's financial crisis. The RUC made its report on June 29, 1984. While Congress did develop a solution to the Railroad Unemployment Insurance (RUI) crisis, passage of the plan was delayed by its inclusion in the Consolidated Omnibus Budget Reconciliation Act of 1985 (H.R. 3128), which stalled in the waning moments of the 1985 session. Most observers now expect Congress to pass the RUI legislation in early 1986 either as part of the reconciliation bill or as separate legislation.

The solution developed by Congress departed significantly from the proposals of the Railroad Unemployment Commission, and from administration proposals. The key provisions of the congressional proposal are the following:

1. The retirement fund will not forgive the interest on its loan to the unemployment fund.
2. Financing of the loan repayment will come from an increase in the existing loan repayment tax that the 1983 railroad retirement tax imposed on employers for the years 1986 to 1990. This tax applies to the first $7,000 of annual wages to each rail employee. Effective June 30, 1986, the 1986 tax will increase from 2 percent of payroll to 4.3 percent; the 1987 tax will increase from 2.3 percent to 4.7 percent; the 1988 tax will increase from 2.6 percent to 6 percents; the 1989 tax will remain at 2.9 percent; and the 1990 tax will remain at 3.2 percent.
3. Any new loans from the retirement fund will be paid by an additional 3.5 percent surtax if the existing tax receipts do not cover the loan.
4. The unemployment fund will receive permanent authority to borrow from the retirement fund. This replaces the temporary authority that expired on December 19, 1985.
5. No alterations in uemployment benefits were made.

### (B) GRAMM-RUDMAN-HOLLINGS

The major legislative impact on the railroad retirement system came from the Gramm-Rudman-Hollings Act. This act sets deficit reduction targets for the entire Federal budget. If the Government does not meet these targets, the act imposes automatic, across-the-board cuts on a wide range of Government programs. However, the act exempts many programs—such as Social Security and Medicare—from the automatic cuts. Tier I benefits are among the programs excluded from automatic cuts. Tier II benefits are not excluded, although cuts in tier II can consist of no more than cancellation of scheduled COLA's. The act went into effect immediately, and caused cancellation of the COLA scheduled to go into effect on January 1, 1986. If Congress and the President had agreed on voluntary measures to meet the deficit target for fiscal 1986, the 1986 COLA would have been restored retroactively. However, Congress had until only March 1, 1986, to propose voluntary deficit reduction measures; after that date, the COLA cancellation became permanent.

### (C) TIER I TAXATION

The budget reconciliation bill (H.R. 3128) also included the Treasury's proposal to tax that portion of tier I benefits which are in excess of Social Security benefits. Although some issues prevented the House and Senate from passing a final version of the bill, the railroad retirement tax was not among them. If Congress does pass some form of reconcilation bill in early 1986, observers expect the tax to be included in the bill.

### (D) MISCELLANEOUS BILLS

Although 1985 saw little legislative activity apart from Gramm-Rudman-Hollings, activity concerning the RUI financing crisis, and taxation of benefits, several bills were introduced which await action by Congress in 1986. One of these was the railroad retirement improvements bill introduced in the Senate by Senator Heinz as S. 1176, and in the House of Representatives by Congressman Oberstar as a package of bills—H.R. 2508-16. The package of bills would eliminate the "last person service" requirement, increase the eligibility of divorced spouses for tier I benefits, allow full credit for military service, and allow for increased trial work periods and earnings by disabled beneficiaries. Senator Heinz also introduced a bill, S. 929, to reverse the reduction of the 1985 tier II COLA, which was reduced from 3.5 percent to 2 percent as part of the 1985 Railroad Retirement Solvency Act.

## 4. PROGNOSIS

After years of uncertainity the Railroad Retirement System appears to have weathered the most serious crises in its history. The changes wrought in the past few years have assured adequate financing of the retirement fund and the unemployment fund. Barring a serious recession in the rail industry, or other developments which would drastically alter the ratio of workers to retirees, the system should be able to pay its own way for the forseeable future. Any future legislative activity in the retirement area will probably focus on attempts to eliminate the qualification rules that have developed as the system grew, and which set the system apart from Social Security and private pension systems.

The effect of the Gramm-Rudman-Hollings Act on the Railroad Retirement System is difficult to predict. While tier I benefits are insulated from the automatic spending cuts set forth in the Gramm-Rudman-Hollings Act, Congress might nonetheless cut these benefits in an effort to voluntarily meet its deficit reduction targets, thus avoiding mandatory cuts in other programs. Tier II benefits are now frozen and will remain frozen unless Congress and the President agree on measures—such as tax increases or reductions in defense spending—that will voluntarily meet the deficit targets.

## Chapter 3

# TAXES AND SAVINGS

## OVERVIEW

Older Americans have benefited from special tax advantages since tax-free Social Security benefits were first paid in 1940. The exclusion of Social Security income and other tax advantages enacted subsequently were intended to extend the purchasing power of the limited resources the elderly received. Proposals to reform the tax structure to increase tax equity, and a concern by some that all elderly are not in need of special tax treatment has brought tax advantages for the elderly under review.

The first concrete signs of a change in attitude about special tax provisions for the elderly appeared with the enactment of the Social Security amendments of 1983. As part of a package of changes to solve Social Security financing problems, the 1983 amendments made Social Security and railroad retirement benefits taxable for the first time—generally taxing half of the benefit for those who have substantial income from other sources. The 1983 amendments also eliminated a special tax credit previously available to retired public employees younger than 65 years of age. The most significant effect of the change was to increase tax liability by as much as 2 percent of income for the 10 percent of the elderly taxpayers with the highest incomes.

Legislation in recent years to raise Federal revenues and improve tax equity through broadening of the tax base and greater taxpayer compliance has also changed the way the elderly pay some of their taxes. In the Tax Equity and Fiscal Responsibility Act of 1982, the Congress reduced the obligation to estimate and pay quarterly taxes on pension and interest income by requiring payors of pension annuities and interest to withhold taxes. While pension withholding has remained in effect, public pressure forced the repeal of withholding on interest and dividend income in 1983. As part of the Deficit Reduction Act of 1984 [DEFRA], the Congress provided the Secretary of the Treasury with greater discretion to waive penalties for elderly and other taxpayers who, through ignorance of the requirement, fail to file estimated quarterly tax payments.

In 1985, attention turned to the efforts for comprehensive reform to reduce the complexity and improve the fairness of the tax code. In November 1984 the Treasury provided a proposal to the President for tax reform, universally known as Treasury I. In May 1985 the President submitted a revised proposal to the Congress. Both Treasury I and Treasury II propose to eliminate and cut back on current deductions, while reducing overall tax rates and broadening the tax base. Some of these proposals would eliminate one or more special exemptions or deductions for the elderly. Most, however, would leave the Social Security exemption and other special provisions in place.

The changing attitude toward tax advantages for the elderly has been accompanied by a shift in Federal policy concerning savings and investment. As part of a national strategy to increase capital available for investment, tax incentives for corporate and personal savings were expanded by the Economic Recovery Tax Act of 1981. Although some analysts have suggested that increased receipt of asset income would improve retirement income adequacy, most of these incentives were not directed solely at improving retirement income.

There is now an increasing awareness of the cost of tax incentives for savings and asset accumulation, and a growing doubt about the contribution of additional savings incentives toward capital formation and retirement income. Some believe that tax-favored treatment does not result in new savings for retirement, but simply encourages individuals who already have after-tax savings to shift those savings into tax-favored vehicles. To the extent that this is true, it gives a windfall to those taxpayers and raises serious questions as to the efficiency of these incentives.

## A. TAXES

### 1. BACKGROUND

Concern about the special tax treatment accorded those 65 and older focuses on whether these provisions are equitable and whether they still serve a worthwhile purpose. Four tax provisions exclusively benefit older persons and others who receive Federal benefits: (1) The exclusion of Social Security and railroad retirement benefits (if their adjusted gross income is below $25,000 for single filers and $32,000 for joint filers), and the exclusion of veteran's benefits; (2) the additional exemption for persons 65 and older; (3) the 15 percent elderly tax credit for disabled and elderly persons with limited incomes; and (4) the one-time exclusion of capital gains from the sale of a home after age 55. The elderly also benefit from tax provisions that are not age-specific, such as medical expense deductions, State and local bond interest exclusion, and deductions for charitable contributions.

#### (A) TAXATION OF GOVERNMENT RETIREMENT INCOME TRANSFERS

Social Security, railroad retirement, and veterans benefits prior to 1983 were, like many other Government transfer payments, exempt from taxation. The original Social Security legislation made no specific reference to the tax treatment of benefits. However, a revenue ruling was issued at the time benefits were first paid, stating: (1) That Congress did not intend for Social Security benefits to be taxed since it did not include a provision to tax them in the law, and (2) that the benefits were intended as gratuities and not earnings-related annuities, and therefore were not taxable.

In 1983, the Congress enacted legislation to restore financial solvency to Social Security. A provision to tax half of the Social Security and railroad retirement benefits of those whose combined income exceeded $25,000 for single filers and $32,000 for joint filers was included in that legislation. (Public Law 98-21). The rationale for this change was to treat Social Security and railroad retirement the same as employer-sponsored pensions for tax purposes, by excluding from taxation only the portion of the benefit attributable to after-tax employee contributions. The limit on taxability protected low- and moderate-income beneficiaries from a sudden increase in tax payments. Full taxation of benefits will phase-in gradually for those whose incomes are now below the fixed limits when, over time, their incomes rise as the limits remain the same.

### (B) EXTRA PERSONAL EXEMPTION FOR ELDERLY, BLIND AND DISABLED

The extra personal exemption for taxpayers 65 and older was added to the tax code in the Revenue Act of 1948 to compensate for perceived economic handicaps of the elderly, as well as to provide some relief from the effects of the post-war economy. The elderly were provided special treatment because they could not benefit from the rapid wage gains being realized by workers in the post-war economy. At the time it was enacted, this provision removed an estimated 1.4 million elderly taxpayers from the rolls, and reduced the tax burden for another 3.7 million.[1]

### (C) ELDERLY TAX CREDIT

The retirement income credit was enacted with the codification of the Internal Revenue Code (IRC) in 1954. The purpose of the credit was to extend tax treatment parallel to the exemption of Social Security income to those whose retirement income came primarily from non-Social Security covered employment or independent savings. Persons 65 and older or under 65 and receiving a public pension were allowed to take a tax credit equal to 15 percent of their pension (and, in the case of those 65 and older, interest and dividend) income. The amount of retirement income qualifying for the tax credit did not include earned income over certain limits nor Social Security or other tax-exempt benefits.

In 1976, the Congress limited the credit to those 65 and older with low-incomes and renamed it the Elderly Tax Credit. Targeting was achieved by placing a ceiling on the amount of the credit and by reducing the amount credited for tax-exempt retirement income and adjusted gross earnings. The credit for those under 65 was not modified in 1976, but was eliminated in the 1983 Social Security amendments. At the same time, the tax credit for those 65 and older was increased by doubling the maximum tax credit amount.

### (D) ONE-TIME EXCLUSION OF CAPITAL GAINS ON SALE OF HOME

The one-time home sale capital gains exclusion originated in the Revenue Act of 1964. At the time it was viewed as a way to protect homeowners from incurring tax liability on gains which were thought to result largely from inflation. In addition, advocates maintained that the Government should not tax away assets people had accumulated for retirement, nor discourage the elderly from selling their homes. The capital gains tax was seen as a substantial burden for the elderly in the case of home sales. Originally the provision excluded capital gains of $20,000 in the adjusted sales price of the house for persons 65 and older. In recent years, the Congress raised the maximum excludable gain to $125,000 to reflect increases in average market prices for housing, and lowered the age that the exclusion can be taken to 55.

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[1] U.S. Congress. Senate. Committee on Finance. Revenue Act of 1948; Report to accompany H.R. 4790. 80th Cong. 2d Sess. Washington: U.S. Govt. Print. Off., 1948, p. 21.

## 2. Tax Incidence Among the Elderly

These exclusions and deductions enable many of the elderly to pay no taxes at all. In 1981, only 40 percent of the population aged 65 and older (10.4 million persons) paid income taxes.[2] The elderly who do pay taxes, however, pay higher taxes on average than the nonelderly. Elderly taxpayers in 1981 had higher effective tax rates (18.9 percent) and greater tax liability ($4,191) than nonelderly taxpayers (16.2 percent and $3,647 respectively), despite the fact that the average adjusted gross income (AGI) of elderly taxpayers ($22,205) was slightly lower than the average AGI for nonelderly taxpayers ($22,460).[3]

The difference in tax liability may be due in part to a greater tendency among the elderly to claim the standard deduction rather than to itemize. In 1981, 30 percent of the elderly itemized their deductions, compared to 34 percent of the nonelderly. However those elderly who itemized their deductions claimed higher average deductions than nonelderly itemizers. Overall, the elderly claimed an average of $8,774 in total deductions compared to an average of $8,064 claimed by the nonelderly. Average deductions for medical expenses and charitable contributions claimed by the elderly were more than twice those claimed by the nonelderly.

## 3. Issues

### (A) TAX EQUITY AND EFFICIENCY

Tax policy analysts are concerned that the current income tax system, with its complex array of exemptions and deductions causes distortions in economic incentives, inequities in the distributio of the tax burden, and too many opportunities for tax sheltering. The fairness of the tax system is usually judged in terms of vertical and horizontal equity. Vertical equity means that tax burdens are distributed in relation to the taxpayer's ability to pay—those with more income pay higher proportional taxes. Horizontal equity means that individuals with equal income have equal tax burdens. The current progressive income tax has a fair degree of vertical equity, but the complex system of exemptions and deductions result in substantial horizontal inequity.

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[2] IRS. Statistics of Income, 1981, Individual Income tax Returns. Table 2.5.

[3] Holik, Dan and John Kozielec. Taxpayers Age 65 and Over, 1977–81. SOI Bulletin, 4:1–16, Summer 1984.

Generally, the special tax provisions for the elderly are not considered to be inequitable. A 1982 Treasury Department study examined the distribution of tax benefits among higher income groups. The study ranked tax expenditures in terms of the percentage received by taxpayers with 1981 adjusted gross income (AGI) exceeding $50,000. Overall, the 4.4 percent of the taxpayers had more than $50,000 in AGI and these taxpayers paid 32.9 percent of taxes after credits. The study found that of the tax provisions specifically benefiting the elderly, the most regressive was the one-time exclusion of capital gains from home sales. This tax benefit was ranked the 16th most regressive among the 33 benefits studied—27.6 percent of its benefits went to taxpayers with AGI's in excess of $50,000. The double exemption for the elderly was ranked 22d in regressivity, 15.2 percent of benefits going to the highest income brackets. The least regressive of the special elderly provisions, the Elderly Tax Credit, was ranked 30th out of 33 benefits. Only 2.2 percent of its benefits went to those with AGI's in excess of $50,000.[4]

There is a growing sense, however, that the tax system in general benefits the rich at the expense of working people and that this sense of unfairness is contributing to a decline in taxpayer compliance. Tax legislation to raise tax revenues to reduce the budget deficit has attempted in recent years to respond to these concerns. In the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], the Deficit Reduction Act of 1984 [DEFRA], and most recently in the House's passage of its comprehensive tax reform bill, H.R. 3838, the Congress focused on closing tax "loopholes," broadening the tax base by including more items in taxable income, limiting exemptions and deductions, and improving taxpayer compliance. These revenue-raising "reforms" have largely been promoted as means of improving the fairness of the income tax.

The efficiency of the individual income tax is judged in terms of its effects on relative prices and the allocation of resources. Any income tax tends to distort relative prices. Tax exemptions and deductions are specifically designed to alter relative prices, often to achieve particular social policy goals. They often have unintended effects on labor supply and consumption which do not contribute to social policy aims. Tax reform efforts to simplify the tax code, lower marginal tax rates and eliminate many current tax deductions and exemptions are promoted as a way to reduce the work and savings disincentives which some believe are inherent in the current tax system. Proponents of reform argue that the progressive tax structure results in higher marginal tax rates which discourage people from working additional hours or raising their gross incomes. A flat tax rate would eliminate the effect of taxing additional income at higher marginal rates. Some argue that a reduction in marginal tax rates would improve the after-tax rate of return on investment and encourage savings.

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[4] Joint Economic Committee, Treasury Study on the Distribution of Tax Expenditures, Nov 20, 1982.

### (B) SIMPLICITY

The tax law with its host of exemptions and deductions has become increasingly complex and costly to administer. The diversity of regulations, forms, and procedures confuse taxpayers, and reduce compliance with the law. As a result, the administrative requirements and tax losses become increasingly costly to both the Federal budget and the economy.

The tax law is not uniquely complex for the elderly, but the elderly especially can become confused by changes in their tax liability resulting from changes in their status. Retirement often results in a change in the sources and tax treatment of income. The tax rules that become applicable can be confusing, particularly since the tax treatment of some income may change over time or be subject to alternative rules. For example, pension income is taxed under one of two alternative rules which permit the recovery of employee contributions taxfree while taxing employer contributions and earnings on the trust. Individuals who have had all of their taxes withheld from their wages or who have claimed only the standard deduction during their working lives may not be prepared to minimize their tax liability on pension and asset income, or accurately file estimated quarterly tax payments during the taxable year.

## 4. Legislation in 1986

### (A) PROPOSALS FOR COMPREHENSIVE TAX REFORM

A turning point in the drive for a fair and simple income tax came with the introduction of the President's tax proposal for "fairness, growth and simplicity", and the House of Representatives consideration and final passage of its own tax reform legislation, H.R. 3838. These tax proposals followed the reintroduction of several major tax reform bills early in the first session of the 99th Congress to replace the current progressive structure with flat tax rates and a broad definition of taxable income. Two of the proposals had become particularly prominent in the 98th Congress: The Bradley-Gephardt "Fair Tax Act" and the Kemp-Kasten "Fair and Simple Tax" [FAST].

Bradley-Gephardt, Kemp-Kasten, and the President's proposals are grounded in the effort to improve the fairness or perceived fairness of the tax system. This is achieved largely through an expansion of the tax base: counting some noncash compensation (employee benefits and fringes) as income and eliminating tax deductions and exclusions often only available to and certainly worth more to high-income taxpayers. In addition, all the proposals seek to simplify taxation—to reduce the need for ordinary taxpayers to maintain detailed records or pay for professional assistance, and make it easier for people to comply with the law. This is achieved largely by the use of a flat-rate tax and the elimination of some tax deductions. The proposals have also, to a greater or lesser degree, avoided redistributing the tax burden across income classes. Finally, all three proposals have aimed at "revenue neutrality," that is, neither increasing nor decreasing Federal revenue. Yet, despite their broad similarities, these proposals differ on a number of points.

Most notably, tax rates, the tax treatment of Social Security, personal exemptions, tax credits for the elderly and disabled, and itemized deductions.

All four tax reform proposals replace the current progressive tax rates with a single tax rate or stepped flat-tax rates. Bradley-Gephardt would apply a flat 14 percent tax rate to all income, but would add a surtax 12 to 16 percent on income above certain levels. Kemp-Kasten would impose a single tax of 24 percent on all income below the Social Security taxable maximum, and would tax income above the taxable maximum at 20 percent. The President proposed three separate rates of 15, 25, and 35 percent.

The Kasten-Kemp bill would reduce the maximum inclusion of Social Security benefits from half of the benefits under current law to one-quarter, if the sum of the individual's modified gross income and one-half of his or her Social Security benefits exceeds the specified base amount. Bradley-Gephardt would retain the current tax treatment of Social Security and railroad retirement benefits.

The Bradley-Gephardt proposal would raise the personal exemptions and standard deductions, and leave the additional exemption for the elderly and the blind intact. Kemp-Kasten would raise the personal exemptions and standard deductions even more, and also retain additional exemption for the elderly and blind. Both Bradley-Gephardt and Kemp-Kasten would repeal the tax credit for the elderly and disabled. By contrast, the President's proposal would also increase the personal exemption for all taxpayers, and expand the elderly tax credit, but would repeal the extra personal exemption for elderly. The dollar amounts for the earned income tax credit would be reduced and indexed under Kemp-Kasten. Bradley-Gephardt would leave them unchanged.

The itemized deductions of greatest interest to the elderly—medical, and charitable contributions—would be retained under these proposals. The President, however, proposed to tax the first $10 to $25 a family receives in employer paid health insurance, effectively raising their "income" subject to taxes by $300. Bradley-Gephardt contains a similar proposal. All three proposals would repeal the deduction for certain types of State and local taxes. The American Association of Retired Persons (AARP) testified before House Ways and Means Committee that this provision was of particular concern to the elderly because of their reliance on State community services programs.

On balance, all flat-tax proposals would generally lower effective tax rates for people who take standard deductions, increasing effective rates for those who have itemized. Since the elderly are more likely to take standard deductions, tax reform might actually reduce the net tax burden on the elderly as a group. According to Treasury Department estimates, under the President's proposal, with its revised personal exemption and increased elderly tax credit would raise the level of tax-free income to the elderly.

The tax reform proposals now being considered neither raise nor lower tax revenues in total. All have the effect of redistributing the tax burden—from individuals to corporations or from nonitemizers to itemizers. The President's proposal would reduce individual tax payment overall by 7 percent and increase corporate tax payments by 9 percent. In general, while each of these proposals would modify the tax treatment for some or all elderly, only Kemp-Kasten would significantly affect the tax burden of the elderly as a group. All proposals are redistributive and in most cases they would reduce the tax burden for elderly at lower levels of income and with few or no deductions.

### (B) H.R. 3838: TAX REFORM ACT

In late November, the House Ways and Means Committee completed work on a comprehensive tax reform bill, H.R. 3838, and brought it to the House floor where it was passed on December 17. The House bill differs from the President's proposal in that it generally reduces taxes for individual, particularly lower income, taxpayers, raises the top tax rate, and raises additional corporate taxes through a minimum corporate tax.

Critics of the legislation charge that although it will result in some far-reaching changes, it is no longer truly tax reform since it does little to change the complicated scheme of deductions and exclusions.

The major provisions of H.R. 3838 which affect the elderly are as follows:

—The maximum tax rate for individuals is reduced to 38 percent;

—Retain the current law treatment of Social Security and railroad retirement benefits;

—eliminate the extra personal exemption for elderly and blind taxpayers;

—increase the value of the personal exemption for taxpayers who do not itemize deductions to $2,000, and for taxpayers who do itemize to $1,500; and

—raise the standard deduction for elderly taxpayers $600 above the increase for all taxpayers. The standard deduction is unavailable to taxpayers who itemize.

For the most part, itemized deductions of particular interest to the elderly, the charitable contribution, mortgage interest, and the deduction for State and local taxes remain virtually the same as under current law.

H.R. 3838 is generally more generous to lower income taxpayers than the President's proposal, although this generosity is concentrated largely on the nonelderly poor. The tax burden for the lowest income bracket will be reduced by more than 75 percent, according to the Joint Tax Committee. According to Robert Greenstein, director of the Center for Budget and Policy Priorities, H.R. 3838 is more generous to the low income because of the increase in the standard deduction, and in the earned income tax credit which goes to working families to offset the Social Security payroll tax.[5]

The elderly benefit less from H.R. 3838 than the nonelderly, although the taxes of most elderly taxpayers would be reduced if H.R. 3838 were enacted. There would be a strong incentive for the elderly not to itemize their deductions, which comports with the general goal of simplifying the taxing process. Like other taxpayers, elderly who itemize are required to offset their personal exemption by the first $500 of their itemized deductions. In addition, for the elderly and blind only, there is a $600 add-on to the standard deduction which helps only those who do not itemize, since itemizers do not take the standard deduction. However, the elimination of the extra personal exemption for the elderly, as well as the change in both the personal exemption and standard deduction for all taxpayers who itemize, has the effect of raising taxes for some middle and upper income elderly. For the most part, those paying higher taxes under H.R. 3838 would be persons who itemized under the old law, but whose deductions would be too low to benefit from itemizing under H.R. 3838. In effect, even with the special $600 add-on to the standard deduction for the elderly and blind, H.R. 3838 tends to make the tax burden for elderly and nonelderly taxpayers more equal.

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[5] Congressional Quarterly, Nov. 30, 1985, p. 2491.

## B. SAVINGS

### 1. BACKGROUND

Since 1981 there has been considerable emphasis on increasing the amount of capital available for investment. By definition, increased investment must be accompanied by an increase in savings. Total national savings comes from three sources: Individuals saving their personal income; businesses retaining their profits; and the Government savings when tax revenues exceed expenditures. As part of the trend to increase investment generally, new or expanded incentives for personal savings and capital accumulation were enacted.

Simultaneous to this emphasis on capital accumulation, retirement income experts suggested that personal savings be increased for retirement-specific purposes. Many retirees are primarily dependent on Social Security for their income. Thus some analysts favor a better balance between Social Security, pensions, and personal savings as sources of income for retirees. The growing financial crisis which faced Social Security in the early 1980's reinforced the sense that individuals should be encouraged to increase their preretirement savings efforts.

For a number of years the "life-cycle" theory of savings has been advanced by some analysts to explain personal savings behavior. It postulates that individuals save little as young adults, increase their savings in middle age, then consume those savings in retirement. Survey data suggests that savings behavior is largely a function of available income versus current consumption needs, an equation which changes over the course of most individuals' lifetimes.[6]

The consequences of the life-cycle savings postulate raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those already saving at above-average rates: Taxpayers who are reaching maturity, earning above-average incomes and thus subject to relatively high marginal tax rates. Whether this group is presently responding to these incentives by creating new savings, or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject for disagreement among policy analysts. For taxpayers who are young or have lower incomes, the tax incentives may be of little value. Expanding savings in this group necessitates a trade-off of increased savings for current consumption, which they are not under most circumstances inclined to do. As a result, some observers have concluded that tax incentives will contribute little to the adequacy of retirement income for most individuals, especially those at the lower end of the income spectrum.

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[6] Two such surveys include the Survey of Changes in Family Finances (SCFF) commissioned by the Federal Reserve Board and the Department of Labor's Personal Consumption Expenditures Surveys (CES), which tend to confirm the rise and then fall of savings rates as individuals age. Wachtel, Paul. The Impact of Demographic Changes on Household Savings, 1950–2050. President's Commission on Pension Policy. Coming of Age: Toward a National Retirement Income Policy. Technical Appendix, Chapter 30. Washington DC, February 1981.

The dual interest in increased capital accumulation and improved retirement income adequacy resulted in the expansion of tax incentives for personal retirement savings, such as IRA's, by the Economic Recovery Tax Act of 1981 (ERTA, Public Law 97-34). Despite Congress' favorable disposition toward such incentives, debate continues over the importance and efficiency of expanded tax incentives for personal savings as a means to raise capital for national investment goals. Retirement income analysts have also questioned whether the incentives will create significant net new retirement savings. Each of these issues may receive further attention in 1986 in the context of the efforts to improve the fairness, simplicity, and efficiency of Federal tax incentives.

The proportion of aged units reporting receipt of asset income has increased gradually over the last decade: From 49 percent in 1971, 56 percent in 1976, 66 percent in 1980, to 68 percent in 1982.[7] Some of this increase may be due to improvements on survey questionnaires which increases the accuracy of asset income reporting. However, the consistency of the upward trend suggests that some degree of real growth has taken place.

Three observations about these data are appropriate. First, the prevalence of asset income receipt is nearly the same across age groups: the difference between the 55-61 age cohort and those age 80 or over was only 2 percentage points. Second, the incidence of asset income receipt by sex and race for those over 65 shows substantial variations. Men are more likely to receive asset income in retirement than women; whites are more likely to receive asset income than blacks. This generally reflects the increased probability that women and blacks have retirement income equal to or less than 125 percent of the poverty line.

Finally, the likelihood of asset income receipt is directly proportionate to total income. Asset income is much more important to individuals with high levels of retirement income. Only a third of aged units with income less than $5,000 receive income from assets at all, while 86 percent of those with incomes between $10,000 and $20,000 and 96 percent of those with income over $20,000 receive some asset income. More than one-quarter (28 percent) of aged units with incomes greater than $20,000 relied on assets to provide more than half of their retirement income. Only 9 percent of those with income less than $5,000 relied on assets for more than half their retirement income, and of these, most depended on assets to provide 100 percent of their retirement income.

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[7] Grad, Susan. Income of the Population 55 and Over, 1982. Social Security Administration, Office of Retirement and Survivors Insurance and Office of Policy. Govt. Print. Off., Washington, DC. March 1984. See also Upp, Melinda. Relative Importance of Various Income Sources of the Aged, 1980. Social Security Bulletin. Gov't Print. Off., Washington, DC. January 1983.

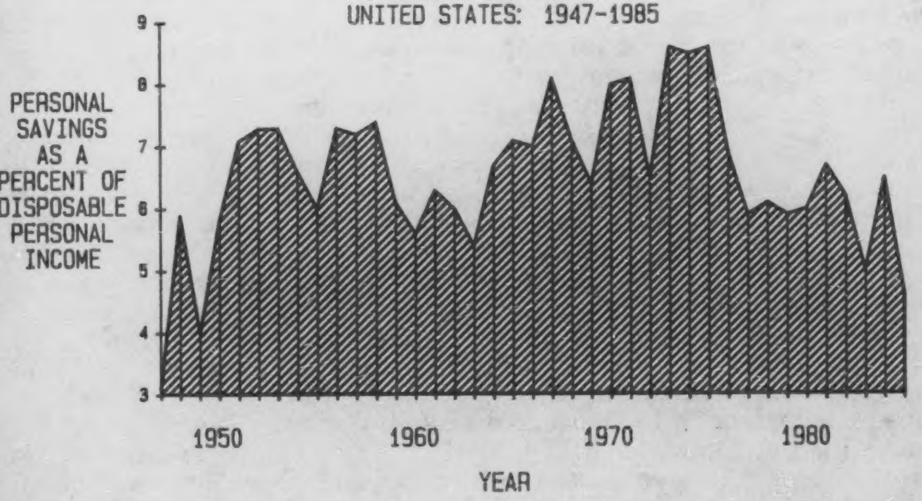
Historically, income from savings and other assets has furnished a small but growing portion of total retirement income. In 1982, 25 percent of total money income came from asset income compared to about 16 percent 15 years ago. Assets remain a far more important source of income for the retired population on the whole than pension annuities, largely because less than one in three retirees receive pension benefits.

## 2. ISSUES

The effort to increase national investment springs from a perception that governmental, institutional, and personal savings rates are lower than the level necessary to support a healthy economy. Focusing on personal savings, except for a period during World War II (when personal savings approached 25 percent of income) the personal savings rate in the United States has ranged between 5 and 8 percent of disposable income. Many potential causes for these variations have been suggested, including demographic shifts in the age and composition of families, workforces and efforts to maintain levels of consumption in the face of inflation. Personal savings rates in the United States have historically been substantially lower than in other industrialized countries. In some cases it is only half to a third of the savings rates in European countries.[8]

CHART 3-1

PERSONAL SAVINGS RATE
UNITED STATES: 1947-1985



Source: National Income Product Accounts, Bureau of Economic Analysis, Department of Commerce.

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[8] U.S. Department of Commerce. International Economic Indicators, vol. VII, No. 4. Washington DC, December 1982.

In the fall of 1985 the Commerce Department released figures indicating that the personal savings rate for the third quarter of 1985 was the lowest it had been since the 1950's; 2.9 percent. Analysts suggested that without savings in corporate pensions, the country actually experienced a dis-savings overall. In part, this dramatically low figure reflects widespread use of consumer credit to purchase goods—cars, for example. Nevertheless, economists have argued that the "buy now" attitude of Americans is on the rise, posing a real hazard to their financial futures. More importantly, this low savings rate, in the face of increased incentives to save in the code gives rise to doubts about the effectiveness of those incentives. If retirement savings only take place in employer-sponsored plans, then policy analysts argue that retirement income goals might be better served by policies favoring these, rather than individual savings vehicles.

Even assuming present tax policy does create new personal savings, critics suggest this may not guarantee an increase in total national savings available for investment. Federal budget surpluses constitute savings as well; the loss of Federal tax revenues resulting from the tax incentives may offset the new personal savings being generated. Under this analysis, net national savings would be increased only when net new personal savings exceeded the Federal tax revenue foregone as a result of tax-favored treatment.

Recent studies of national retirement policy have recommended strengthening individual savings for retirement. Because historical rates of after-tax savings have been low, emphasis has frequently been placed on tax incentives to encourage savings in the form of voluntary tax-deferred capital accumulation mechanisms.

The final report of the President's Commission on Pension Policy, issued in February 1981, recommended several steps to improve the adequacy of retirement savings including the creation of a refundable tax credit for employee contributions to pension plans and individual retirement savings. Similarly, the final report of the National Commission on Social Security recommended increased contribution limits for IRA's. In September of the same year, the Committee for Economic Development—an independent, nonprofit research and educational organization—issued its report entitled "Reforming Retirement Policies." The committee recommended a strategy to increase personal retirement savings which included tax-favored contributions by employees covered by pension plans to IRA's, Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased savings opportunity. In each Congress since the passage of the Employee Retirement Income Security Act [ERISA] in 1974 there have been expansions in tax-perferred savings devices. This was most obvious in the passage of ERTA in 1981. From the perspective of retirement-specific savings, the most important provisions were those expanding the availability of IRA's, simplified employee pensions [SEP's] Keogh accounts and employee stock ownership plans [ESOP's]. ERTA was followed by additional expansion of Keogh accounts in the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], which sought to equalize the treatment of contributions to Keogh accounts with the treatment of contributions to employer-sponsored defined contribution plans.

The evolution of Congress' attitude toward expanded use of tax incentives to achieve socially desirable goals holds important implications for tax-favored retirement savings. When there is increasing competition for Federal tax expenditures the continued existence of tax incentives depends in part on whether they can stand scrutiny, on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy. In 1986 efforts to reform the structure of the Internal Revenue Code (IRC) will lead to the reevaluation of all the current tax incentives in the code, including incentives for retirement savings.

### (A) INDIVIDUAL RETIREMENT ACCOUNTS [IRA'S]

Since the opportunity to save in an IRA was extended to pension covered workers by the Economic Recovery Tax Act of 1981 [ERTA], contributions to and assets held by IRA depositors have increased dramatically. IRA and Keogh deposits totaled $202.4 billion by the end of the first half of 1985, up from $142.2 billion in the same month of 1984, a 42.3 percent increase. ERTA broadened IRA eligibility so that individuals already participating in pension plans could contribute to an IRA as well. IRS data for 1982, the first year of universal IRA availability, recorded 12.1 million contributions to IRA's; nearly four times the number who contributed in 1981.[9]

IRA's constitute a major short-term revenue loss to the Federal Government, which may now equal as much as one-third the revenue loss attributable to tax expenditures on public and private employer pension plans. When ERTA was enacted in 1981, the Congress anticipated revenue losses due to IRA deposits of $0.98 billion for 1982 and $1.35 billion in 1983. The Treasury estimates of actual revenue loss for those years was $4.8 and $10.0 billion respectively. Even if IRA contribution growth is now beginning to level off, the program is already much larger than Congress anticipated.

The rapid growth of IRA's poses a dilemma for employers as well as Federal retirement income policy. As IRA's come to play an increasingly important role in the retirement planning of employees, they may diminish the importance of the pension bond which links the interests of employers and employees. Employers may indeed face new problems in attempting to provide retirement benefits to their workforces.

In recent years questions have been raised about the efficiency of the IRA tax benefit in stimulating new retirement savings. First, does the tax incentive really attract savings from individuals who would be unlikely to save for retirement otherwise? Second, does the IRA tax incentive encourage additional savings or does it merely redirect existing savings to a tax-favored account? Third, are IRA's retirement savings or are they tax-favored savings accounts used for other purposes before retirement?

Evidence suggests that those who use the IRA most might otherwise be expected to save without a tax benefit. Low-wage earners barely use IRA's. The participation rate among those with less than $20,000 income is two-fifths that of middle-income taxpayers

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[9] Employee Benefit Research Institute. EBRI Issue Brief #32, Individual Retirement Accounts: Characteristics and Policy Implications. Washington, DC, July 1984.* * *

($20,000–$50,000 annual income) and one-fifth that of high-income taxpayers ($50,000 or more annual income). Younger wage earners, as a group, are also not spurred by the tax incentive to use IRA's. As the life-cycle savings hypothesis suggests, employees nearing normal retirement age are three times more likely to contribute to an IRA than workers in their twenties. Those without other retirement benefits also appear to be less likely to use an IRA. Employees with job tenures greater than 5 years display a higher propensity toward IRA participation at all income levels. For those not covered by employer pensions, utilization generally increases with age, but is lower across all income groups than for those who are covered by employer pensions. In fact, 46 percent of IRA accounts are held by individuals with vested pension rights.[10]

Though a low proportion of low-income taxpayers utilize IRA's relative to higher income counterparts, those low-income individuals who do contribute to an IRA are more likely than their high-income counterparts to make the contributions from salary rather than pre-existing savings. High-income taxpayers are apparently more often motivated to contribute to IRA's by a desire to reduce their tax liability than to save for retirement.[11]

One of the stated objectives in the creation of IRA's was to provide to tax incentive for increased savings among those in greatest need. This need appears to be most pressing among those with low pension coverage and benefit receipt resulting from employment instability or low average career compensation. However, the likelihood that a taxpayer will establish an IRA increases with job and income stability. Thus, the tax incentive appears to be most attractive to taxpayers with relatively less need of a savings incentive. As a matter of tax policy, IRA's may be an inefficient way of improving the retirement income of low-income taxpayers.

An additional issue is whether all IRA savings are in fact retirement savings or whether IRA's offer the opportunity for abuse as a tax shelter. Most IRA savers probably view their account as retirement savings and are inhibited by the 10 percent penalty on withdrawals before age 59½ from taking savings out. However, those who do not intend to use the IRA to save for retirement can still receive tax benefits from an IRA even with early withdrawals. Most analysts agree that the additional buildup of earnings in the IRA that occurs because the earnings are not taxed will surpass the value of the 10 percent penalty after only a few years, depending upon the interest earned. Some advertising for IRA savings has emphasized the weakness of the penalty and promoted IRA's as short-term tax shelters. Although the tax advantage of an IRA is greatest for those who can defer their savings until retirement, they are not limited to savings deferred for retirement.

An additional concern is that the IRA is not equally available to all taxpayers who might want to save for retirement. Currently, nonworking spouses of workers saving in an IRA may only contribute an additional $250 a year. Some contend that this creates an inequity between two-earner couples who can contribute $4,000 a year and one-earner couples who can only contribute $2,250 in the aggregate. They argue it arbitarily reduces the retirement income of spouses, primarily women, who spend part or all of time out of the paid workforce. Those who oppose liberalization of the contribution rules contend that any increase will primarily advantage middle and upper income taxpayers, since the small percentage of low-income taxpayers who do utilize IRA's often do not contribute the full $2,000 permitted them each year.

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[10] Ibid.* * *

[11] Ibid.* * *

### (B) EMPLOYEE STOCK OWNERSHIP PLANS [ESOP'S]

Employee stock ownership plans [ESOP's] have been promoted as a means for transferring the ownership of a company's capital to it workers. Although ESOP's can become a valuable source of retirement income to supplement social security, pension benefits, and personal savings, they are not designed (nor intended) to be an employees sole or primary retirement savings vehicles, or a replacement for traditional pension arrangements. Such plans can offer employees potential investment returns exceeding those of standard pension plans if the company is growing at a substantial rate or is consistently profitable, but at a considerably increased risk. Employees not only bear the risk of the plan's investment performance, but also bear the additional risk of relying on a nondiversified investment portfolio. Because the value of a company's shares can fluctuate over a wide range in response to the employer's fortunes, an ESOP cannot be considered a secure primary retirement vehicle for participants. Thus there has been considerable concern over recent action by some corporations which have terminated their defined benefit pension plans and replaced them with ESOP's.

The most sensitive issue surrounding employee stock ownership plans is their expanding use in closely held corporations, where the value of the stock to employees is uncertain. For employees to have meaningful owership interest in their employer through participation in an ESOP the stock must be fairly valued and the employees must have some control over the way in which the stock is voted. But in a privately held corporation one or both of these elements may be missing or constrained. It is difficult to value stock contributed to the ESOP of a privately owned corporation because there is no ready market for its resale. This creates an enormous potential for abuse. By overvaluing stock contributions an employer-owner can inflate the tax benefit received while employees may be hurt because the real value of the stock is less than its nominal worth.

Although Congress has clearly expressed its intent to encourage employee stock ownership, the effectiveness of the ownership and productivity incentives which form the basis of congressional policy have been debated. In the case of ESOP's in closely held corporations with limited voting rights passthrough, the absence of voting rights and a ready market for resale cast doubt on the existence of any realistic incentive at all. Even in publicly traded corporations with full passthrough voting, some employee organizations have argued that stock in the ESOP does not accumulated fast enough compared to the total amount of stock outstanding to give employees any significant voice in corporate decisionmaking. As a result, several employee organizations have opposed the implementation of ESOP's unless coupled to representation on the employer's board of directors.

The ESOP concept has been supported by Congress in spite of these unresolved issues. It is important to note, however, that since an ESOP's value is inextricably tied to the financial health of the employer, their implementation should be traded off against current wages rather than retirement benefits when being used to save financially distressed employers. If an ESOP is used to replace pension benefits, the demise of the employer could wipe out a substantial portion of an employee's retirement income as well. But by exchanging the ESOP for current wages an employee's retirement benefit remains insulated to a some degree from the consequences of the employer's potential demise, while a much stronger link is forged between productivity incentives and the employee's present compensation.

The interests of older workers near retirement differ greatly from those of younger workers, such that an ESOP cannot be utilized as a replacement for traditional pension arrangements without having a differential effect on the interests of certain groups of employees.

## 2. Legislation in 1985

### (A) THE HOUSE TAX REFORM BILL: H.R. 3838

The primary legislation dealing with savings incentives in 1985 was the Tax Reform Act, H.R. 3838, which passed the House of Representatives on December 17, 1985. On the whole, H.R. 3838 would pare back many of the investment tax incentives enacted by Congress in 1981. For the individual taxpayer, however, the changes are not as dramatic as to the corporate taxpayer. An estimated $141 billion tax burden would shift from individual to corporate taxpayers over the next 5 years. Since CODA's are addressed in chapter 3, the discussion in this chapter will focus on the IRA and ESOP savings vehicles.

The House generally rejected proposals to improve IRA tax incentives. While Treasury II had called for an increase of $1,750, to a maximum of $2,000 for contributions to an IRA on behalf of a nonemployed spouse—equal to the deduction available to a employed person, the House bill would maintain the current $250 deduction. In addition, H.R. 3838 incorporates a provision which integrates the limits for contributions to an IRA along with salary reduction contributions to an employer-sponsored 401(k) plan. The bill would limit salary reduction to $7,000 annually, and reduce the available contribution to an IRA dollar for dollar for contributions to a 401(k) plan. This provision reflects the philosophy that Federal tax policy ought to apply some aggregate limit to voluntary savings for retirement and to provide more equal treatment between employees with no employer plan, and employees whose employers offer generous tax-favored savings opportunities. In effect, it seeks to encourage those who would save by reducing their taxable income to do so in a 401(k) vehicle to achieve maximum benefits. It partially restores the IRA to its pre-ERTA status, where employees covered by a pension plan were ineligible for IRA's, by in effect disqualifying individuals who avail themselves of salary reduction from establishing IRA's.

H.R. 3838 also places restrictions on the use of ESOP's. Under the bill, additional qualification requirements are provided for ESOP's. These additional qualification requirements (a) require more rapid (10-year graded) vesting; (b) modify the ESOP nondiscrimination rules to limit the annual amount of employer contributions that may be allocated to employees who are officers, shareholders, or highly compensated; (c) expand the pass-through voting requirements applicable to employer securities held by an ESOP; (d) permit an eligible plan participant to direct the ESOP trustee to diversify a portion of that participant's ESOP account balance; and (e) modify the distribution and put option requirements including the timing of the employer's payment of the put option price. The Ways and Means Committee was concerned that the current law encourages ESOP's to provide tax benefits to employers and others engaged in ESOP transactions without ensuring increased rights of ownership for participating employees. The bill also repeals the special ESOP tax credit and deductions on dividends paid on employer securities, and certain other special provisions. The Ways and Means Committee indicated that cutbacks on certain tax benefits previously given to ESOP's was necessary in order to retain other "more important" incentives.

### (B) AN ALTERNATIVE: THE RETIREMENT INCOME POLICY ACT S. 1784

On October 22, Senator John Heinz and Senator John Chafee introduced the Retirement Income Policy Act of 1985 (S. 1784). The bill was simultaneously introduced in the House of Representatives by Representative William Clay, Chairman of the House Education and Labor Subcommittee (H.R. 3594). In the context of the broader issues of retirement income policy, RIPA seeks to encourage the individual savings component of retirement income. RIPA integrates IRA and 401(k) salary reduction limits in the same manner as H.R. 3838, and raises the penalty for premature distributions from IRA's to 20 percent. In addition, it promotes IRA's as a portability vehicle for pension benefits by requiring that all premature distributions from plans be mandatorily transferred to IRA's. Rather than establishing a static dollar limit on contributions to retirement savings plans, RIPA establishes limits related to the Social Security wage base. Many analysts feel that this will encourage savings for retirement by making individuals more confident of future contribution limits. RIPA does not specifically address itself to ESOP's, but to the extent that an ESOP is the primary retirement plan of an employer, it would have to meet certain basic benefit requirements.

## C. PROGNOSIS

Tax reform is an effort to provide a fairer distribution of tax benefits—to equalize the tax payments of taxpayers with equal incomes. The intent of the various tax reform proposals is to redistribute the tax burden without adding any new benefits or losing revenue. It proceeds on the theory that by curbing or eliminating some tax benefits, an overall reduction in rates be possible thus, on balance, reducing the tax burden on individuals. Recent tax reform proposals also reflect an interest in reducing the burden on low-income individuals, particularly families.

In the context of the effort to draft a "revenue-neutral" tax reform bill, there is a concern that within the total amount dedicated to pensions and savings, some of the existing tax benefits need to be distributed more fairly. There are proposals to restructure and integrate the various savings incentives to focus the limited tax resources where they can most effectively encourage new savings and to reduce the use of multiple tax-favored savings vehicles by individuals who save substantially without tax incentives. IRA's, ESOP's and 401(k) accounts have the potential to expand capital accumulation and increase the assets of future generations of the elderly. The interest in tax reform, however, is to achieve this result with the most efficient use of existing tax benefits.

Most of these issues will be confronted in the spring of 1986 when the Senate Finance Committee is expected to proceed with the markup of its own version of a tax reform bill. Although there are no simple or pure solutions to these concerns, whatever marginal changes are adopted should move tax policy gently in the direction of constructing a simpler and fairer tax system.

# Chapter 4

# EMPLOYMENT

## OVERVIEW

For decades, employment and retirement policies in the United States have been directed toward encouraging early retirement. For example, Social Security was developed during the Great Depression, in part, to ease a sufficient number of older workers out of the labor force to make room for younger workers. Similarly, 9 out of 10 private pension plans offer financial incentives for early retirement; that is, prior to the normal retirement age (usually 65). When these programs are combined with employer administered mandatory retirement policies, a highly competitive work force, and rapidly changing technologies, it is not surprising that few older persons remain employed after their 65th birthday.

The statistics on older worker employment are startling. Since 1900, the employment rate among men 65 and older has declined by nearly 50 percent. Today, only 18.8 percent of this older male age group are employed, as are only 8.2 percent of older women. The early retirement trend has extended down to the middle-aged as well. Since 1960, employment rates among men aged 55 to 64 have dropped by one-sixth, from 87 to 70 percent. Three-quarters of all new Social Security beneficiaries each year retire well before their 65th birthday, and most begin collecting benefits at the earliest possible age, age 62. A July 1985 General Accounting Office (GAO) study found that almost half of the individuals who receive private pensions start receiving them by age 62 and almost 60 percent start receiving them before reaching 65. The increase in private pension receipt among persons under age 65 also reflects the trend toward earlier retirement.

This early retirement phenomenon raises serious policy concerns. First, the future economic security of older Americans is jeopardized by early labor force withdrawal. Those who do not work are three times more likely to fall below the poverty level. Second, earlier retirement contributes to the financial strain on Social Security and private pension plans. Third, serious shortages of skilled labor may develop in certain industries unless the early retirement trend is reversed. In contrast to these pressures to keep older persons in the labor force, however, it appears that labor demand is not sufficient to satisfy older persons' current employment needs. Therefore, the conflict between early retirement and the need to reverse the decline in labor force participation rates has become a major public policy dilemma.

In addition to the economic arguments for increasing the labor force participation rates among older workers, there are also compelling issues of civil rights involved. Age, like race, sex, religion, and national origin, is a protected category under Federal statutes. Eliminating age bias in the workplace is consistent with a tradition in America of struggle against arbitrary policies which discriminate against individuals because of their basic beliefs or their personal characteristics. The nearly unanimous opposition to mandatory retirement policies by the American public is one indicator of the strong sentiment against arbitrary age bias in employment. Yet, despite these civil rights arguments, the protections against age discrimination remain incomplete and somewhat ineffectual.

These twin problems—the early retirement trend and infringement on the civil rights of older workers—comprise the underpinnings of the public policy debate on employment for the aging. Steps have been taken in recent years to increase incentives for delayed retirement and to remove barriers to continued employment. Nonetheless, the trend toward earlier retirement continues and complaints of age discrimination in the work force are increasing. During the first session of the 99th Congress, certain Members introduced various legislation to address these matters. Congress, as a whole, however, took no action and the prospects for significant activity during the second session are dim.

## A. BACKGROUND

### 1. Age Discrimination

Numerous obstacles to older worker employment exist in the labor force. These include: (1) negative stereotypes about aging and productivity; (2) job demands and schedule constraints which are inconsistent with the skills and needs of older workers; and (3) policies which make it undesirable to remain in the labor force, such as early retirement incentives and discontinued pension credits. Several of these have their roots in age discrimination.

Age discrimination in employment plays a pernicious role in blocking employment opportunities for older workers. It is not a new problem. The emergence of discriminatory employment practices for older workers can be traced to the late 1800's in the United States. There is some evidence that even in the late 1800's, negative attitudes about the capacities and productivity of the aged were already common throughout the Nation. The development of retirement as a social pattern in industry may have served to enhance and legitimize employment discrimination practices despite early evidence that older workers were capable, conscientious, and productive employees.

Today, age discrimination in employment is widespread. There is no agreement on the exact nature of the problem, nor is there a consensus on how to solve it. But few would disagree that the problem is real and that it affects the lives of millions of Americans. Despite Federal legislation to ban most forms of age discrimination from the workplace, most Americans believe age discrimination remains a serious problem. Two nationwide surveys by Louis Harris & Associates—one in 1975, the other in 1981—found nearly identical results; 8 out of 10 Americans believe that "most employers discriminate against older people and make it difficult for them to find work."

The perception of widespread age discrimination held by the public is shared by a majority of business leaders. Most employers believe age discrimination exists, according to a 1981 nationwide survey of 552 employers conducted by William M. Mercer, Inc. The following key points summarize the survey's findings:

—61 percent of employers believe older workers today are discriminated against in the employment marketplace;

—22 percent claim it is unlikely that, without the present legal constraints, the company would hire someone over age 50 for a position other than senior management;

—20 percent admit that older workers (other than senior executives) have less of an opportunity for promotions or training; and

—12 percent admit that older workers' pay raises are not as large as those of younger workers in the same category.

The forms of age discrimination range from the more obvious mandatory retirement ages, to more subtle job harassment and early retirement incentives. Each of these represent not only a threat to the well-being of older individuals, but also undermine the economic stability of the Nation's retirement income systems and, to a lesser extent, the larger economy as well. Age discrimination reduces the work efforts of older people, encourages premature labor force withdrawal, and increases the load on an already burdened Social Security system and on private pensions. Without adequate solutions to the problems of age discrimination and without incentives to encourage more older workers to remain employed longer, the Nation could be facing a serious economic as well as social crisis in the future.

In order to encourage equal employment opportunities for older persons, Congress enacted the Age Discrimination in Employment Act [ADEA] in 1967, which became effective on June 12, 1968 (Public Law 90-202). The ADEA legislation was the culmination of years of debate concerning the problems of providing equal opportunity for older workers in employment. At issue was the need to balance the competing interests of the right of the older worker to be free from age discrimination in all aspects of employment, and the employer's prerogative to control the managerial decisions which make a business profitable. The provisions of the ADEA attempt to balance these competing interests by prohibiting age discrimination based upon an employer's arbitrary policies which would prevent employment of individuals above a certain age. Arbitrary age limits may not be used as conclusive determinations of nonemployability, so that employment decisions regarding older persons should be based on an individual assessment of each applicant's or employee's potential or ability.

Specifically, the Age Discrimination in Employment Act was enacted "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment." The act currently prohibits employment discrimination against persons aged 40 to 70. These age limits were chosen to focus coverage on workers especially likely to experience job discrimination because of their age. The upper age limit was originally set at 65 because it was the common retirement age in U.S. industry and the normal eligibility age for full Social Security benefits. The act specifies that actions otherwise deemed unlawful may be permitted if they are based upon the following considerations:

—Where age is a bona fide occupational qualification reasonably necessary to normal operations of a particular business;

—Where differentiation is based on reasonable factors other than age (for example, the use of physical examinations relating to minimum standards reasonably necessary for specific work to be performed on a job);

—To observe the terms of a bona fide seniority system or a bona fide employee benefit plan such as a retirement, pension, or insurance plan, with the qualification that no seniority system or benefit plan may require or permit the involuntary retirement of any individual who is covered by the ADEA; and

—Where an employee is discharged for good cause.

In addition, an executive or high-ranking, policymaking employee in the private sector entitled to annual private retirement benefits of at least $44,000 could be compulsorily retired at age 65, simply because of age. This is known as the "executive exemption" and it was designed to allow turnover at the top levels of the organization. While it has strong support among business leaders, recent evidence shows that it is used only infrequently by a small number of employers.

Since 1967, the ADEA has been amended six times. The first set of amendments occurred in 1974, when the provisions of the act were extended to include Federal, State, and local government employers. Also, the number of workers covered was increased by exempting only those employers who have fewer than 20 employees. Previous law exempted employers with 25 or fewer employees. In 1978, the act was amended to extend protection to age 70 for private sector, State, and local government employers, and by removing the upper age limit for employees of the Federal Government. Regulations implementing the 1978 amendments, however, specified that employers are not required to credit years of service worked beyond age 65 to final pension benefit levels. This was, and continues to be, a disincentive to continue work beyond age 65.

The act was amended in 1982 by a provision included in the Tax Equity and Fiscal Responsibility Act [TEFRA]. This provision, referred to as the "working aged" clause, requires employers to retain their over-65 workers on the company health plan rather than automatically shifting them to Medicare. Under previous law, Medicare was the primary payer and private plans were secondary. Now, the situation is reversed, with Medicare acting as the payer of last resort. This provision was designed to be a cost saver for the Medicare program, but it is viewed as a new obstacle to employment for older workers because it increases the costs of employment and, for many small companies, there are serious problems in finding insurance coverage at all for these older workers.

The most recent amendments to the ADEA were contained in the 1984 reauthorization of the Older Americans Act. Public Law 98-459, section 11(f), amends the ADEA by extending protections to

U.S. citizens who are employed by U.S. employers in a foreign country. Support for this legislation was based in part on the belief that many such workers are really an extension of the U.S. work force who should not be subject to possible age discrimination just because they are assigned abroad. Section 12(c)(1) of the ADEA, the executive exemption, was also amended by raising, from $27,000 to $44,000, the annual private retirement benefit level for determination of exemption from provisions of the act for persons in bona fide executive or high policymaking positions.

The Equal Employment Opportunity Commission [EEOC], which enforces the laws prohibiting discrimination has reported a 100 percent increase in age-related claims since 1971. During fiscal year 1985, the Commission filed 96 lawsuits under the ADEA, an increase of almost 50 percent over the 67 actions in fiscal year 1984. This is the largest number of ADEA lawsuits filed by the Federal Government in any 1-year period since the ADEA was enacted in 1967. In 1980, one-fifth of the U.S. population was over 55 years old. Demographic statistics project that this figure will climb to approximately 25 percent by the year 2000. While the total U.S. population is expected to increase by one-third between 1982 and 2050, the older population (aged 55 and older) is expected to increase 113 percent. Eventually, this demographic trend is expected to mature the U.S. work force. This is significant when one considers the fact that the typical age-discrimination plaintiff is 55 years old. More older people in the labor force will mean greater competition among older and middle-age workers and litigation under the ADEA is certain to continue to increase.

## 2. FEDERAL PROGRAMS

A second thrust of the Federal Government is to provide funds for training disadvantaged and dislocated workers to assist them in becoming more employable. This section describes two Federal programs designed to promote the employment opportunities of older workers: The Job Training Partnership Act [JTPA] program and the Community Service Employment Program under title V of the Older Americans Act.

### A. THE JOB TRAINING PARTNERSHIP ACT

The new JTPA, enacted by the 97th Congress, and which went into effect October 1, 1983, establishes a nationwide system of job training programs administered jointly by local governments and private sector planning agencies. For program year 1985, which began July 1 and runs through June 30, 1986, slightly more than $3.6 billion has been appropriated for JTPA programs as part of the fiscal year 1985 appropriations act (Public Law 98-619). The fiscal year 1986 appropriations (Public Law 99-178) contained $3.4 billion for JTPA.

JTPA establishes two major training programs: Title II for economically disadvantaged youth and adults, with no upper age limit; and title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. Under the title II-A program, which authorizes training for disadvantaged adults and youth, funds are allotted among States according to the following three equally weighted factors: Number of unemployed individuals living in areas with jobless rates of at least 6.5 percent for the previous year; number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and the number of economically disadvantaged individuals. Training under title II-A can include on-job-training, classroom training, remedial education, employability development, and a limited amount of work experience. For the period October 1983 through June 1984, about 11,700 persons 55 and older participated in the title II-A program, representing 2 percent of total participants.

Section 124(a-d) of JTPA also establishes a statewide program of job training for economically disadvantaged workers age 55 or older. Governors are required to set aside 3 percent of their title II-A allotments for this older workers program. During the current program year, from July 1, 1985 to June 30, 1986, the older workers' setaside is funded at $57 million. This level is maintained for the 1986 program year. The older workers program under section 124 of JPTA is meant to be operated in conjunction with public agencies, private nonprofit organizations, and private industries. Programs must be designed to assure the training and placement of older workers in jobs with private business concerns.

For workers who have been or are about to be laid off, are eligible for or have exhausted their entitlement to unemployment compensation, and are unlikely to return to their previous occupation or industry, Congress created title III. The dislocated workers program is administered by the States and includes such services as job search assistance, job development, training in job skills for which demand exceeds supply, relocation assistance and activities conducted with employers or labor unions to provide early intervention in case of a plant closing. During the period between October 1983 and June 1984, about 3,500 persons 55 and over had been served by the title III program (7 percent of program terminations).

It is, unfortunately, too early to make an adequate evaluation of the program's success with regard to older workers. According to testimony presented to Congress by the National Council on the Aging in July 1985, the impact of JTPA on mature and older workers is probably minimal. The need for and importance of JTPA, however, is underscored by a November 1984 Department of Labor study on displaced workers. According to the study, 5.1 million workers lost their jobs due to the decline of an industry or a plant closing between 1979 and 1984. The chance of reemployment for these displaced workers declined significantly with age. Only 41 percent of those between 55 and 64 were able to reenter the labor force in any capacity (as compared to 70 percent for those between the ages of 20 and 24). Only 21 percent of those over 65 became reemployed and of those who found a job, almost half (45 percent) received lower pay than at their previous position and one-third took salary cuts of more than 20 percent. The study showed that the older an individual was when he lost his job, the longer he would be unemployed and the more likely he would become completely discouraged and drop out of the labor force altogether. Overall, there are more than 1.2 million "discouraged" workers in the Nation.

### B. TITLE V OF THE OLDER AMERICANS ACT

The Community Service Employment Program [CSEP] for Older Americans was given statutory life under title IX of the "Older Americans Comprehensive Services Amendments of 1973." Its purpose is "to promote useful part-time opportunities in community service activities for unemployed low income persons." Amendments passed in 1978 redesignated the program as title V of the Older Americans Act and it was reauthorized through fiscal year 1987 by Public Law 459, the "Older Americans Act Amendments of 1984," enacted on October 9, 1984. The program responds to certain identified needs of older persons by providing opportunities for part-time employment and income. It also serves as a source of labor for various community service activities. The program can also assist unemployed older persons move into permanent unsubsidized employment.

The program is administered by the Department of Labor (DOL), which awards funds to national sponsoring organizations and to State agencies. Persons eligible under the program are those who are 55 years of age and older (with priority given to persons 60 years and older), who are unemployed, and whose income level is not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services (in 1985, $6,565 for a one-person household and $8,813 for a two-person household). Enrollees are paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, whichever is less. Federal funds may be used to compensate participants for up to 13,000 of work per year, including orientation and training. Participants work an average of 20–25 hours per week. In addition to wages, enrollees receive physical examinations, personal and job-related counseling and, under certain circumstances, transportation for employment purposes. Participants may also receive training, which is usually on-the-job training and oriented toward teaching and upgrading job skills.

Proposed revised regulations on title V were published in the Federal Register on July 19, 1985 (FR, v. 50, no. 139). The July 19 proposed regulations incorporate some of the legislative requirements added by major amendments to the Older Americans Act in 1978, 1981, and 1984 and set forth the requirements for title V grant planning and application procedures, project operations, limitations on Federal funds, administrative standards and procedures, interagency agreements and DOL assessment and evaluation of employment sponsors. As of the date of this writing, the regulations are winding their way through the final approval process. The regulations do not appear to be controversial and have, reportedly, not met with any stiff opposition.

In recent years, the Reagan administration has made a number of proposals which would have significantly altered the Older Americans Act's employment focus. These have ranged from proposals to completely eliminate the title V program to proposals to change the administrative and program structure by transferring all or a portion of the program from the Department of Labor to the Department of Health and Human Services, and to replace the subsidized job concept with one which would assist older persons to create their own business. All of these proposals were ultimately rejected by Congress which has supported the title V program in its current form and which has voted for program expansion by increasing appropriations 22 percent from its 1980 level. In its fiscal year 1986 budget submission, the administration made no recommendations for changes in the existing structure of the program.

CSEP is one of the few remaining direct job creation programs since the elimination of the Comprehensive Employment and Training Act and the Public Service Employment programs. The program has seen steady increases in funding and participant enrollment since its inception. In the 1968–69 program year, the first full year of its operation in a form similar to the current program, participant enrollment was 2,400 with a budget of $5.5 million. In fiscal year 1985, title V funding appropriations are $326 million (representing about 28 percent of total funds appropriated under the Older Americans Act of 1965) and funding about 63,783 positions.

Although the program supports a relatively small number of jobs—about 64,000 in the 1985–86 program year—it is the most visible federally supported employment program for older persons. Evaluations and program reviews conducted on the program in recent years have generally proven positive and in 1985 the Department of Labor began its first major program evaluation. Despite proposals by the Reagan administration to change or terminate the program, Congress has supported the program by increasing appropriations and has made no major structural changes.

## B. ISSUES

### 1. MANDATORY RETIREMENT

The most clearcut form of age discrimination is mandatory retirement rules. According to a recent Department of Labor study, 51 percent of the Nation's work force faced an arbitrary mandatory retirement age in 1980, usually age 70, while 45 percent faced no mandatory retirement age. Mandatory retirement rules are subsiding, but they persist for a variety of reasons. Many employers perceive older workers as a group to be ill-suited for certain jobs because of declining mental and physical capacity, an inability to learn, a lack of creativity, and inflexibility. Vast amounts of research on the abilities of older workers, however, consistently refute these employer-held stereotypes. Several Senate bills pending in the 99th Congress would remove the upper age limit in the ADEA. The effect of removing the upper age limit in the ADEA would be to protect workers aged 40 and above against discrimination in all types of employment actions, including mandatory retirement, hiring, promotions, and terms and conditions of employment.

Organizations for the aged and others in favor of eliminating mandatory retirement argue that judging a person's qualification for a job solely on the basis of age, without regard to fitness for a job, is inequitable and that chronological age alone is a poor predictor of ability to perform a job. Other arguments for eliminating mandatory retirement include: (1) Older workers discriminated against may lose income; (2) the loss of status associated with the loss of a job may result in the deterioration of mental and physical health for the older person; (3) the loss of skills and experience from the work force due to mandatory retirement results in a loss to our Nation's productivity and gross national product (GNP); and (4) allowing workers to stay on their job longer helps the financial status of the Social Security and other retirement systems because payment of full retirement benefits is deferred until a later age and continued contributions will flow into these programs.

Employers and others in favor of retaining mandatory retirement note that older persons, as a group, may be less well suited for some jobs than younger workers because declining physical and mental capacity are found in greater proportion among older persons and because they do not learn new skills as easily as younger persons. Other arguments against eliminating mandatory retirement include: (1) Mandatory retirement preserves the dignity of the older worker who is no longer capable of performing his or her job adequately, and who would otherwise be singled out for discharge in a personally damaging proceeding; (2) mandatory retirement provides a predictable situation allowing both management and employees to plan for the future; (3) older workers can often retire with Social Security or other retirement income, making jobs (and promotions) available to younger workers who do not have other income potential; and (4) by opening up jobs, mandatory retirement also provides more opportunities to women and minorities who are under-represented in certain occupations.

The Reagan administration's support for legislation to abolish mandatory retirement has been inconsistent. In April 1982, the President endorsed the elimination of mandatory retirement, saying, "I will back legislation which eliminates mandatory retirement requirements in government and private industry based solely on age."

Soon after that statement was made, however, administration officials stated before congressional committees that the President supported removal of the upper age limit only for forced retirement, but that other aspects of employment, such as hiring and promotions, could be subject to age 70 limits. Since then, the administration has given lukewarm support to even such a narrowly focused bill.

The key political issues in the debate over mandatory retirement have little to do with the merits of the issue. Indeed, there is remarkably little opposition to the full elimination of mandatory retirement. A survey released in January 1985 showed that 70 percent of Americans disapprove of mandatory retirement and there is little evidence that a glut of older workers is holding back younger ones. Instead, the debate hinges on three related concerns: (1) Whether amendments to the ADEA should also modify the enforcement procedures specified in the original act; (2) whether an exemption allowing mandatory retirement at age 70 should be included for tenured faculty at institutions of higher education; and (3) whether an exemption allowing early forced retirement should be added for State and local law enforcement and firefighting personnel. Each of these is discussed below.

### 2. ADEA ENFORCEMENT PROCEDURES

One legislative proposal would eliminate jury trials and liquidated damage awards under the ADEA. This bill had support from business associations, such as the Chamber of Commerce, but was vigorously opposed by aging organizations and the plaintiffs' bar. ADEA enforcement procedures are currently modeled after those in the Fair Labor Standards Act [FLSA]. Employers argue that title VII of the Civil Rights Act—which prohibits employment discrimination on the basis of race, color, sex, religion, or national origin—does not allow jury trials nor liquidated damage awards. Age discrimination cases, they argue, should not be treated differently. Some believe that litigating an age claim before a jury decreases an employer's chances because juries tend to concern themselves only with whether the employer's actions are fair as opposed to nondiscriminatory. They also believe that juries tend to sympathize with the plight of aging plaintiffs and make unreasonably large awards against private business.

Those in favor of retaining the enforcement procedures in current law note that liquidated damages are only payable if there is a willful violation of the act, making the provision a deterrent to such violations. Advocates for liquidated damages also say that such awards are important because judges are reluctant to order job reinstatement or monetary awards beyond the date of the decision, even though the plaintiff may continue to experience problems securing appropriate employment. On the jury trial issue, there is no clear-cut evidence that juries are more sympathetic to aggrieved older workers than are judges. A recent study by Barbara Fosberg, in which 239 ADEA cases were analyzed, indicates that jury verdicts show no bias toward plaintiffs.

### 3. MANDATORY RETIREMENT FOR TENURED FACULTY

An exemption in the 1978 amendments to the ADEA allowed mandatory retirement of tenured faculty at institutions of higher education at age 65 until July 1, 1982, when the age was raised to 70. Several legislative proposals would allow tenured faculty to be mandatorily retired, in the event that the current age 70 cap is lifted for other workers.

The DOL recommends a temporary exemption for faculty at age 70, if the age cap is eliminated for others, to allow colleges and universities time to evaluate retirement trends. Several points have been made in support of the mandatory retirement of tenured faculty:

—According to DOL, the salaries of faculty nearing retirement are about twice those of newly hired faculty. Prohibiting mandatory retirement might exacerbate the financial problems colleges and universities are facing because of the reductions in public funds and student enrollments. Reduced enrollments, because of fewer numbers in the traditional college age group, mean fewer opportunities to hire new faculty.

—Prohibiting mandatory retirement may make it more difficult for higher education institutions to employ more women and minorities as faculty members.

—Governing boards and State institutions may reevaluate the tenure system if there is no mandatory retirement age. Tenure protects academic freedom by prohibiting dismissals except under specific conditions. Some would argue that without a mandatory retirement age, tenure would guarantee indefinite employment—a situation which would be unacceptable to university administrators and which would eventually jeopardize the tenure system.

The DOL study indicates that the consequences of raising the retirement age to 70 for faculty include modest cost increases and decreased new faculty appointments, but the duration of the impact on higher education faculty, at least from raising mandatory retirement from age 65 to 70, will be short lived. It adds, however, that "removal of any mandatory retirement age may pose more difficult adjustment problems."

According to testimony before the Labor and Human Resources Committee, faculty and higher education administrators are generally in agreement in seeking a permanent exemption for any uncapping of the mandatory retirement age for tenured faculty. The American Federation of Teachers [AFT], however, and reportedly the National Education Association [NEA], oppose such exemptions for faculty.

Those who oppose the exemption believe that there are not sufficient reasons to single out faculty for special, discriminatory treatment. The NEA calls it double discrimination—once on the basis of age and again on the basis of occupation. Opponents of the exemption argue that colleges and universities are using mandatory retirement as a way to rid themselves of unproductive professors, instead of dealing directly with a problem that can afflict faculty members of any age. They claim that there is no evidence that many professors would stay past 70 even if they could, and that predictions of dire consequences from uncapping the retirement age may be exaggerated. According to the Teachers Insurance Annuity Association and College Retirement Equities Fund, the average age at which faculty members begin collecting their pensions—which usually represents a retirement date—has been declining over the past 10 years.

### 4. EXEMPTION FOR STATE AND LOCAL PUBLIC SAFETY OFFICERS

As earlier noted, the ADEA allows an exception against age discrimination in the workplace where "age is a bona fide occupational qualification reasonably necessary to the normal operation of a particular business, or where the differentiation is based on reasonable factors other than age." The bona fide occupational qualification [BFOQ] defense has been most successful in cases that involve the public safety. In general, courts have allowed maximum hiring ages and mandatory retirement ages for bus drivers and airline pilots, and, on occasion, police officers and firefighters because the safety of the public was at stake. The courts, however, have been inconsistent and the lack of clear judicial guidance has prompted calls for reform.

Several bills introduced in the 99th Congress would exempt State and local government firefighters and law enforcement officers from protections of the act related to hiring and discharging. If enacted, these amendments would allow age to be a determining factor in hiring or discharging public safety officers, but such employees would still be protected from age discrimination in promotions, compensation and other terms, conditions, and privileges of employment.

The issue of whether public safety officers should be treated like other employees under the ADEA arose after the Supreme Court, on March 2, 1983, in *EEOC* v. *Wyoming,* determined that the State's game wardens were covered by the ADEA. Wyoming's policy of mandatory retirement at age 55 for State game wardens was ruled invalid unless the State could show that age is a BFOQ for game wardens. Wyoming had not attempted to establish a BFOQ in this case, but had instead argued that application of the ADEA to the State was precluded by constraints imposed by the 10th amendment on Congress' commerce powers—an argument not sustained by the Court.

Many States and localities have mandatory retirement age policies below age 70 for public safety officers and are concerned about the impact this decision will have. As a result, legislation has been introduced to exempt public safety officers from some or all of the ADEA provisions. Supporters of such legislation note that Federal law generally requires mandatory retirement at age 55 for Federal law enforcement officers and firefighters and say there is nothing to justify treating State and local personnel differently. They also argue that the mental and physical demands, and safety considerations for the public, the individual, and coworkers who depend on each other in emergency situations, warrant mandatory retirement ages below 70 for these State and local workers. Sponsors of the legislation believe that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a BFOQ under the ADEA—as allowed in the *Wyoming* case—because of conflicting court decisions; and even if possible, would require costly and time consuming litigation.

In an interesting development along these lines, in June 1985, the Supreme Court rendered two decisions in cases arising under the ADEA favorable to employees who had challenged the mandatory retirement policies of their employers. The first case, *Johnson* v. *Mayor and City Council of Baltimore,* Nos. 84-518 and 84-710 (June 18, 1985), involved six firefighters who challenged the City of Baltimore's municipal code provision that established a mandatory retirement age at 55 for firefighters. The Court of Appeals, accepting the city's argument, had held that the Federal civil service statute, which requires most Federal firefighters to retire at age 55, constituted a bona fide occupational qualification (BFOQ) for the position of firefighters employed by the city. The Supreme Court reversed this decision, stating that nothing in the *Wyoming* decision or the ADEA warrants the conclusion that a Federal rule, not found in the ADEA, and by its terms applicable only to Federal employees, necessarily authorizes a State or local government to maintain a mandatory retirement age as a matter of law. The Court found that it was Congress indisputable intent to permit deviations from the mandate of the ADEA only in light of a particularized, factual showing. The Court concluded that Congress decision to retire certain Federal employees at an early age was not based on a BFOQ, but instead dealt with idiosyncratic problems of Federal employees in the Federal civil service. Accordingly, the Court ruled that a State or private employer cannot look to exemptions under Federal law as dispositive of BFOQ exemptions under the ADEA. There is a need, the Court said, to consider the actual tasks of the employees and the circumstances of employment to determine when to impose a mandatory retirement age.

The second case, *Western Airlines, Inc.* v. *Criswell*, No. 84-127 (June 18, 1985), raised a challenge under the ADEA to Western Airline's requirement that flight engineers, who do not operate flight controls as part of the cockpit's crew unless the pilot and copilot become incapacitated, were subject to mandatory retirement at age 60. The Supreme Court upheld a jury verdict for the plaintiffs against an airline defense that the age 60 requirement constituted a BFOQ. The Court confirmed that the BFOQ defense is available only if it is reasonably necessary to the normal operation or essence of a defendant's business. The Court also noted that an employer could establish this defense only by proving that substantially all persons over an age limit would be unable to perform safely and efficiently the duties of the job, or that it would be impossible or highly impractical to deal with older employees on an individualized basis.

In both of these cases, a unanimous Court seemed to be looking very critically upon attempts to expand the BFOQ defense beyond specific high risk occupations. The Court also stressed the relationship between individual performance and employment in a particular task, rather than reliance on a standard of chronological age disqualification. Thus, by adopting a very narrow reading of the BFOQ exemption, the Court appears to have strongly endorsed individualized determinations. The fate of airline pilots and certain other occupations remain undecided—but the direction the Court took in the *Johnson* and *Western* cases was widely acclaimed by older workers advocates and aging organizations.

Those opposed to exempting safety officers from the ADEA note that age affects each individual differently, and they say there are tests that can be used to measure the effects of age on individuals, including those that measure general fitness, cardiovascular condition, and reaction time. Employers have questioned the feasibility of individual employee evaluations, and some have cited the difficulty involved in administering the tests because of the technological limitations concerning what human characteristics can be reliably evaluated, the equivocal nature of test results, and economic costs.

In general, the courts have upheld age as a BFOQ when employers were able to demonstrate that all or nearly all workers beyond a specified age could not perform safely or effectively, or that individual testing of workers was either impractical or insufficiently developed. As a result, individual testing policies and procedures to replace age restriction policies in public safety occupations have recently gained attention. An important contribution to knowledge in this area is a September 1985 report entitled "Measuring Vitality and Performance in Aging Workers," prepared by the Congressional Research Service at the request of the House Select Committee on Aging, which presents the scientific capabilities and limitations of selected testing procedures. While the controversy concerning individual worker evaluations as an alternative to age limitations is far from over, reports such as this will help to achieve an ideal level of protection to public safety while guarding employees against arbitrary age restrictions. In the meantime, technology for scientifically based assessment will continue to develop and to further oust the use of chronological age by employers.

### 5. Pension Accruals

Under the present interpretation of the 1978 amendments to the Age Discrimination in Employment Act, pension plans regulated under the Employee Retirement Income Security Act [ERISA] are not required to continue accrual of pension credits for employees who work beyond normal retirement age. This acts as a disincentive to employment for older workers. Under the currently allowed mandatory retirement age of 70, continued accrual of pension credits would result in an estimated 50,000 more workers age 60 to 70 in the labor force by the year 2000. If the age 70 limit was removed as well, a total of 68,000 more men age 60 to 70 probably would be in the work force by that year. These statistics suggest that the discontinuation of pension benefit accruals are a modest disincentive for continued employment beyond age 65 for at least a portion of the work force.

Following the 1978 ADEA amendments, the Department of Labor [DOL] published an interpretative bulletin on the act in May 1979. The DOL intrepretation allowed employers to cease pension contributions and pension credits for active employees who work beyond the normal retirement age specified in their pension and retirement plans. Specifically, these rules interpret the ADEA to permit pension plans to: (1) cease employer contributions at "normal retirement age" (65 years of age under most plans); (2) cease credit of years of service, salary increases, and benefit improvements which occur after an employee reaches the normal retirement age specified in the plan; and (3) not adjust actuarially the benefits accrued as of normal retirement age for an employee who continues to work beyond that age (29 CFR 860.120).

Shortly after the publication of these interpretations, the administrative and enforcement authority under the ADEA was transferred from DOL to the Equal Employment Opportunity Commission (EEOC). The EEOC subsequently commenced a review of the factors relevant to the DOL interpretation by requesting public comments on the continuation of present practices (48 FR 41436, Sept. 15, 1983). Numerous groups and individuals responded to the request, providing the EEOC with hundreds of pages of information, most of which supported prohibiting employers from discontinuing pension benefit accruals at the normal retirement age. EEOC evaluated the public responses and, on June 26, 1984, voted to rescind the DOL opinion that accruals were not required and to replace it with a new proposal that will require continued contributions and crediting for workers past normal retirement age.

Despite the Commission's unanimous vote to move forward with the change, the regulations must still go through a number of procedural hurdles which may be quite formidable. They must go through a process of obtaining comments from other concerned Government agencies and these final comments are not expected before spring or summer of 1986. In addition, a regulatory impact analysis, prepared by EEOC, must be reviewed by the Office of Management and Budget [OMB] prior to publication. Only if OMB signs off on the regulations will they be published for public comment and final Commission approval. The failure of EEOC to act on its policy change was the basis of an administrative petition for rulemaking filed with the EEOC by several national aging organizations and older workers in October 1985.

Supporters of the current interpretations oppose any change in the status quo on the grounds that a change in the rules would cost employers an exorbitant amount of money. Employers argue that when the Employee Retirement Income Security Act, which regulates private pension plans, was enacted, Congress unequivocally determined that retirement plans would not be required to recognize employment beyond normal retirement age either by accruing benefits or by actuarial adjustments to existing benefits. Further, they suggest that the legislative history of the 1978 amendments to the ADEA confirm congressional intent allowing reductions in employee benefits on the basis of age. If this viewpoint is correct, and the ADEA amendments were not intended to change the intent manifested by Congress at the time ERISA was passed, then legislation is necessary to require employers to continue benefit accruals.

Proponents of continued pension benefit accruals beyond normal retirement age have argued that the current DOL/EEOC interpretations, insofar as they permit pension benefits to be frozen or suspended, are contrary to ADEA's policy promoting employment of older persons by prohibiting employer discrimination against older employees based on age alone. Reversing the 1979 interpretation would advance the individual civil rights of older employees by removing one more barrier to equal employment opportunity for older workers. From this viewpoint, freezing pension benefits at normal retirement age confers an undeserved windfall on employers. They suggest that the purpose of pension plans, which is to increase the retirement income of the elderly, could be furthered at little or marginal cost to the employer by extending the accrual of pension benefits beyond normal retirement age.

In the past there has been a dearth of empirical information to help discern the costs of requiring employers to continue pension contributions. To help rectify this situation, the American Association of Retired Persons commissioned William M. Mercer-Meidinger, Inc., to do a comprehensive study of the cost to employers and the benefits to employees if the practice of ceasing pension contributions was eliminated. The major findings of the October 1985 study, which has been printed by the Special Committee on Aging, are:

1. The total annual value of pension benefits lost because employers do not grant full pension credit to those employees working beyond age 65 is approximately $450 million.
2. If there is no increase in the number of employees over age 65 and pension plans provide continued contributions and

crediting, the increase in the employer cost in the first year would amount to $51.5 million, less than one-tenth of 1 percent (0.08 percent) of total U.S. pension costs. Over 20 years, the annual employer cost increase would remain under 1 percent.

3. As the number of employees over age 65 increases, employer pension costs will decline since the costs of continued contributions and crediting is more than offset by gain that results from the shortened duration of pension payments.

4. If post-65 pension contributions and crediting encourage more employees to work beyond age 65, substantial Social Security benefits would not be paid. The study estimates that if age 65 through 69 employment increases by 10 percent, yearly Social Security benefits not paid would be $295 million.

Opponents of the exemption of pension accruals also note that half of all plan sponsors already permit continued accrual, apparently without putting an undue strain on their plan. This is largely due to the employers' ability to fund such continued accruals over the entire length of an employee's career, thereby spreading out the cost to make it more manageable. Finally, if discontinued accruals cause earlier retirement, pension plans will be required to pay out benefits earlier and for a longer period of time. This negates any savings that might have occurred because of discontinued accruals.

The absence of pension accruals can be very costly to older employees. While relatively few older persons choose to work after age 65, halting accruals for those who do results in a substantial loss of retirement benefits. An October 1984 study by the Employee Benefit Research Institute found that an employee delaying retirement can lose up to half the value of benefits accrued at age 65. This loss, in turn, acts as a disincentive to continued employment and may discourage employees from postponing their retirement. In the face of serious economic pressures on this Nation's retirement income systems, and with a dramatic decrease in new entrants to the labor force, it is imperative that continued employment for older workers be encouraged. Clearly, the benefits associated with eliminating obstacles to employing older workers far outweighs the minimal cost of continued accruals.

### 6. APPRENTICESHIP PROGRAMS

Interpretations currently in effect at the Department of Labor, exempt apprenticeship programs from coverage of the ADEA. This, in effect, permits employers and labor unions to exclude men and women over age 40 from entering these programs solely on the basis of their age. The Department of Labor has viewed the elimination of the exemption as detrimental to the promotion of such programs in the private sector since they are widely seen as a training program for youth in which the initial investment and training can be recouped over the apprentice's worklife. Elimination of the exemption is also opposed on the ground that it will cause an even higher rate of joblessness among this country's youth. The counter to this argument, however, is that the high unemployment rate has continued despite the current regulations, which indicates that age limits in apprenticeship programs do not bear on youth unemployment levels.

A 1983 decision in *Quinn* v. *New York State Electric & Gas Corp.*, 569 F. Supp. 655 (1983), held that neither the language of the ADEA nor its legislative history support a conclusion that Congress intended to exempt apprenticeship programs from the ADEA. Following this decision, the EEOC decided to reconsider the exemption and, on June 13, 1984, voted to rescind the current exemption and issued proposed regulations which would prohibit arbitrary age discrimination in such programs. The regulations, however, have languished before the Office of Management and Budget, apparently because the Department of Labor has opposed the proposed change. In the meantime, the current age restrictions are having a serious adverse effect upon the employment opportunities and economic fortunes of older workers.

### 7. HEALTH COSTS

While we have witnessed a steady decline in labor force participation by older people over the past several decades, concerted efforts are now being directed toward reversing this trend. "Worklife extension" is the term used to describe the move to extend the worklife of older persons willing and able to work. An important theme in the discussion of worklife extension is the health of the older population. Employers and policymakers are concerned about the health implications of extend worklife, especially as they relate to issues of labor supply, productivity, employee health costs, and health maintenance.

A February 1985 information paper entitled "Health and Extended Worklife," prepared for use by the Special Committee on Aging, presents information about the health status of older persons as it may relate to extended work lives. The findings of the study indicate that the noninstitutionalized older population, and particularly the younger members of that population, are healthier than is widely believed. Health is one of several variables which affect the supply of workers, their level of productivity, and their utilization of health services and the new data presented in the paper will assist the Congress and employers in making informed decisions about employment and retirement issues.

Conventional wisdom suggests that older workers are paid more than younger workers for the same job and that, therefore, older workers are more expensive. This rationale has frequently been used to support early retirement programs on the assumption that younger workers can be hired at lower cost to replace older workers. There is, unfortunately, a dearth of empirical information to help discern whether it costs more to employ older workers than younger workers. In September 1984, the Special Committee on Aging released an information paper which examines factors related to patterns of labor costs by age, and discusses direct compensation, employee benefits, turnover, training, performance, and productivity.

The evidence indicates that there are some types of employment costs which vary by age, and that overall compensation costs increase by age, largely because of increasing employee benefit costs.

There is, however, no statistical evidence that direct salarly costs on an economywide basis increase by age. Employee benefit costs are not usually separated by age, and individual employers do not generally make hiring and retention decisions on the basis of benefit costs. General increases in medical care costs, combined with an expanding set of laws and regulations, have served, however, to focus the spotlight on employee benefit costs for older workers, and it is possible that employers will give more consideration to this issue in the future.

The belief that older workers cost more seems generally related to feelings about performance and productivity. There is no statistical evidence to indicate generally poorer performance or productivity by age, and the limited data available refutes the basic notion that older workers are less capable. However, there is a significant issue relating to maintenance of skills and training. Over time, as the nature of work changes and the skills of the employee are not kept up to date, there will be an increasing mismatch of skills to the job, leading to deterioration of performance on that specific job. If older workers are to be cost effective, their skills must be continuously updated through training and education to assure continued productivity. The two major conclusions of the information paper are as follows:

—It is extremely important to encourage the maintenance of skills and lifelong education to prevent older worker obsolescence and to provide individuals with the skills to compete on a fair basis for jobs within or outside of their companies. Up-to-date skills are more important than any age-related capabilities in human resource cost and older worker productivity.

—Legislative and regulatory requirements affecting employment costs for older workers should not place undue cost or administrative problems on employers. Such requirements can discourage the employment of older workers.

Employer's concerns about the rising cost of providing health insurance for older workers has been worsened by recent legislative action. In the last decade there has been an increasing trend by the Federal Government to seek ways to curb the rising cost of Medicare by shifting costs to private payors. The Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], legislated changes in Medicare coverage for older workers. As of January 1983, employers can no longer advise workers that they are to be dropped from company group health insurance plans at age 65 because they are eligible for Medicare. TEFRA requires that company plans bear the primary insurance costs of illness, while Medicare becomes secondary.

The TEFRA requirement will raise employer costs in two ways. First, costs will rise for employees age 65 through 69 who previously were covered by employer plans, because these plans now are the primary payer of benefits. Second, employees age 65 through 69 who previously were excluded from employer health plans must now be covered if the employer offers a plan to any of its employees.

A report released in June 1983, by ICF, Inc., estimated that about 434,000 private sector workers age 65 through 69—about 37 percent of all private sector workers in this age group—will be affected by these changes, at a total cost to employers of about $500 million. About 286,000, or 66 percent, of these workers were previously covered by employer plans. The additional health plan costs for these workers are estimated to be about 8 percent of their total compensation costs before the amendments. In addition, about 148,000 workers who were previously excluded from coverage are likely to be covered by employer plans. The health plan cost of these workers is estimated to be about 13 percent of their total compensation costs before the amendments. The study concludes that these changes may initially reduce the demand for workers of this age by about 1 percent.

Another issue, not discussed in the above study, is the difficulty some employers—particularly those with few employees—are having in finding adequate health insurance coverage for their older workers. Indeed, in 1983 the Wall Street Journal reported that insurance companies know that groups with older people in them will run up bigger medical bills than those with younger participants. As a result, insurance premiums for the group have soared and some insurance companies have gotten out of the small-group business altogether as unprofitable. The employer, in turn, has been forced to shop for cheaper coverage, but even this is becoming more difficult as the companies that still cover small groups are being extra selective. Higher insurance premiums for veteran employers can mean another disincentive for those employers to hire and retain older workers.

Two major provisions in the Deficit Reduction Act of 1984 [DEFRA] will have some effect on the costs of employing older workers and on the costs to older workers of remaining employed longer. The first is section 2301 of DEFRA, which modifies the working age provision—originally included in TEFRA—such that employers must offer group health coverage to an employee who has not reached age 65, if the employee has a spouse age 65 through 69. If such an employee elects the group coverage—versus Medicare coverage for the spouse—the employer must offer coverage that is the same as that offered to employees with spouses under age 65. In such cases, Medicare would be the secondary payor, while the employer sponsored plan would be primary. The implications of this provision for employers are relatively minor when taken alone, but when added to the effects of already existing cost factors they are significant. Now employers have yet another reason not to hire or retain older workers—those under age 65—because if they have an older spouse, the employer, rather than Medicare, is required to pay the health costs for the spouse. These added costs may encourage employers to steer clear of older workers.

The second provision, section 2338 of DEFRA, removes a disincentive to older workers of remaining on their employer's health plan. Under the TEFRA provision, those employees who elected, after age 65, to remain in the employer health plan would have been penalized for not enrolling in part B of Medicare upon their 65th birthday. This penalty amounts to a 10-percent increase on annual premiums for each 12 months that the employee does not enroll after his or her 65th birthday. Since the Medicare coverage was duplicative of the employer plan there was no need to enroll in part B until after retirement—except for the stiff penalty imposed.

DEFRA waives the part B premium for workers and their spouses aged 65 through 69 who elect private coverage under the provisions of TEFRA. It also establishes special enrollment periods for such workers. The waiver applies for the period during which an individual continues to be covered under an employer's group health plan.

Despite concerns among employers about the costs of older workers, the Federal Government is seeking ways of keeping older workers in the labor force. The most notable example of this are the 1983 amendments to the Social Security Act. The compromises that resulted in the amendments (Public Law 98-21) reflect the belief in Congress that older people are healthier today and therefore, can continue to work longer. The desired effect of the amendments is that older workers will be discouraged from leaving the labor force by an increase in the penalty for early retirement, an increase in the age at which full retirement benefits are paid, an increase in the delayed-retirement credit, and a reduction in the penalty on earnings after retirement.

A provision in the Social Security Amendments of 1983 calls for the Secretary of Health and Human Services [HHS] to study the law's implications for workers who, because they are engaged in physically demanding jobs or are unable to extend their working careers for health reasons, may not benefit from improvements in longevity. A full report, including any recommendations for providing protection against risks associated with early retirement because of health reasons, is due to be submitted to Congress by January 1, 1986.

## C. RESPONSES

### 1. LEGISLATION

A number of bills dealing with older workers and age discrimination in employment issues were introduced during the first session of the 99th Congress. The majority of these bills are still at the committee level, awaiting further action. During the first session, Members of Congress were consumed with budgetary concerns and, unfortunately, little attention was paid to older worker issues and programs. While the ultimate outcome of these bills is uncertain at this time, the more important of them will be discussed in the following paragraphs.

A comprehensive bill to eliminate barriers to the employment of older workers and to provide incentives for part-time and full-time employment of older workers was introduced by Senator Cranston on January 1, 1985. S. 2, the Older Americans Employment Opportunities Act of 1985, amends certain Federal laws to: Eliminate the upper age limitation of 70 years of age; prohibit any employee benefit plan from requiring or permitting suspension of an employee's benefit accrual because of age; prohibit an employer from withholding plan benefits because of any increase in the income of the participant due to less than 1,000 hours of employment during a calendar year; include low-income older workers as members of targeted groups for purposes of the tax credit for employment of certain new employees; reduce the rates of employment taxes on employees and on employers by one-half in the case of workers 65 years of age or older; and prohibit discrimination because of age in apprenticeship programs.

On May 2, 1985, Senators Heinz and Glenn introduced S. 1054, the Age Discrimination in Employment Amendments of 1985, to amend the ADEA to remove the maximum age limitation (age 70). A similar bill, H.R. 522, was introduced in the House of Representatives by Congressman Claude Pepper on January 7, 1985. The difference in the two bills is that H.R. 522 includes a provision which allows compulsory retirement of tenured faculty of an institution of higher learning until July 1, 2000, while the Senate bill contains no such exemption. Legislation introduced by the Chairman of the Select Committee on Aging, Congressman Roybal, on March 25, 1985, would remove maximum hiring ages and mandatory retirement ages for selected Federal employees not currently covered by the ADEA (H.R. 1710, Federal Employee Age Discrimination Amendments of 1985).

On the issue of State and local law enforcement officers and firefighters, Senator Bradley introduced a measure to amend the ADEA to exclude State and local law enforcement officers and firefighters from coverage under the act (S. 698, Age Discrimination in Employment Act Public Safety Officers Amendments of 1985, March 20, 1985). A bill introduced by Representative Hughes in the House would also exclude firefighters and law enforcement officers from coverage in hiring or discharging under the ADEA (H.R. 1435, Age Discrimination in Employment Act Public Safety Officers Amendments of 1985, March 6, 1985).

With regard to apprenticeship programs, on February 28, 1985, Senator Riegle introduced S. 550, the Apprenticeship Improvement Act of 1985, to prevent age discrimination in apprenticeship programs. The bill would amend the National Apprenticeship Act to direct the Secretary of Labor, in promoting labor standards for the welfare of apprentices, to ensure that no apprenticeship program discriminates in admission or employment against any individual because of age.

Senator Grassley, Chairman of the Subcommittee on Aging, Labor and Human Resources Committee introduced S. 1427, the Older Americans Pension Benefit Act, to prohibit the suspension of an employee's benefit accrued under a retirement plan solely because of age before accruing the maximum normal retirement benefit. Senator Grassley also chaired a hearing, in October 1985, entitled "Pension Accrual and the Older Worker," to examine issues relating to the legislation to require benefit accruals for persons who work past 65. Companion legislation (H.R 2712, the Older Workers Employment Protection Act of 1985, introduced on June 11, 1985) introduced by Representatives Biaggi, Rinaldo, and Pepper was also considered at the hearing.

One of the most important issues before the Congress today is the need to expand employment opportunities of those older men and women who want to work full or part time. Substantial numbers of retired people would like to do productive work, rather than retire full time, but only if more appropriate and flexible employment opportunities are made available to them and existing financial disincentives are removed. A major problem in the proliferation of innovation among business leaders with regard to older workers policies is the absence of information about models that have been tried in the private sector. Examples of new personnel policies and innovative work options to accommodate the unique needs of older workers are given in a February 1985 information paper, "Personnel Practices for an Aging Work Force: Private Sector Examples," prepared for use by the Special Committee on Aging. The information paper fills an important information gap by providing employers, policymakers, and the general public with descriptions of successful employment practices designed to capitalize on the contributions of older workers.

To commemorate older workers, Senators Heinz and Glenn introduced S.J. Res. 38, authorizing and requesting the President to designate the week of March 10 through 16, 1985, as "National Employ the Older Worker Week." The resolution was passed by Congress and signed into law by the President. The legislation helps to focus public attention on the advantages of employing older individuals. The week is celebrated across the Nation through different programs, ceremonies and activities.

### 2. Regulatory Activities

As previously mentioned, Congress incorporated the enforcement provisions of the Fair Labor Standards Act (FLSA) into the ADEA. The Supreme Court has held that a waiver of claims under the FLSA requires the supervision of the Department of Labor or a court. In *Runyan* v. *National Cash Register Corp.*, 759 F.2d 1253 (6th Cir. April 22, 1985), rehearing granted, June 17, 1985, the court of appeals imposed the FLSA requirement on the age discrimination statute, ruling that ADEA rights may not be waived by a private, unsupervised agreement.

In the past, the EEOC recognized that application of the FLSA enforcement provisions to the ADEA may be interpreted to mean that individuals may not waive their rights or release potential liability even if the action is voluntary and knowing, except under EEOC supervision. On October 7, 1985, however, the EEOC published a proposed administrative exemption and legislative regulation under the ADEA allowing for non-EEOC supervised waivers and releases or private rights as an exemption to the ADEA for "any waiver of rights or release from liability by an employee or job applicant under the act that is voluntary and knowing" (50 FR 40870; Oct. 7, 1985). The exemption would allow employers and employees or job applicants to issue private agreements which contain waivers and/or releases of private rights under the ADEA without the supervision or approval of the EEOC. The Commission has solicited comments on the proposed rule and these comments are now under review. Because the proposal to grant blanket waivers of individuals' ADEA rights without (government supervision represents a significant change in current law and practice, and could threaten older workers' basic rights and protections, their rescission has been urged by Senator Heinz, chairman of the Senate Special Committee on Aging and Representative Roybal, chairman of the House Select Committee on Aging. As of the time of this writing, the Commission is reviewing comments from interested persons and has not yet reached a final decision on the proposed rule.

## D. PROGNOSIS

Despite a broad consensus that individuals should not be discriminated against based on their age, discrimination is still widely practiced and stereotypes of useless, burned-out older workers persist. Protections do exist for older workers to prevent and punish age discrimination—and these are important to the few who take advantage of them—but they are often incomplete and ineffectual. Demographic trends dictate that the ADEA issue will become more active both legally and politically—and will result in increased demand for clearer positions on the language found in the ADEA. While there is no perfect system for correlating age and the attributes required by certain jobs, the decade of the 1980's can be expected to bring increasingly accurate measurements of individual functional ability.

The decades long trend toward earlier retirement continues unabated, and there appears to be nothing on the short-term horizon that will alter that trend. Certain policies and practices, such as the denial of pension credits after age 65, the prevalence of nonactuarially reduced private pension credits offered for early retirement, and lucrative early retirement opportunties, provide strong disincentives to delayed retirement. In the face of these policies and practices, it is unlikely that early retirement will become less popular or necessary in the near term.

Members of Congress are increasingly aware of the potential costs of earlier retirements, but nothing in the first session of the 99th Congress addressed this problem in any significant way. The extensions of the Age Discrimination in Employment Act to Americans working for U.S. firms abroad, and the liberalization of the "executive exemption," will have some beneficial effect on employment patterns of older workers, but these were probably offset in large measure by the extension of the working aged provisions to aged spouses of older workers. The most significant legislation in recent years to have some potential effect on future employment and retirement patterns was the 1983 amendments to the Social Security Act. These amendments increased the costs to older employees of retiring early. It could, therefore, be presumed that older workers may decide to remain on the job longer. Unfortunately, preliminary analyses of survey data on older workers indicate that these disincentives may not affect retirement patterns in any significant way. Their net effect, if these initial studies are correct, would be merely to lower the incomes of future retirees, rather than to encourage longer work lives.

On a more positive note, the Federal Government has taken some positive steps toward improving employment opportunities for older workers. The specific older worker provisions of the Job Training Partnership Act and the title V program are a step in the right direction, toward improvement of the skills of older workers so that they can compete more effectively in the job market. When these efforts are combined with improvements in the economy and a declining unemployment rate, the future could be brighter for those older workers who desire to work and are capable of doing so.

# Part II

# LOW-INCOME ASSISTANCE PROGRAMS

Public policy has long sought to provide an adequate retirement income for most of the population through the combination of Social Security, private pensions, and personal savings. However, it has also recognized the need for programs to supplement the basic incomes of the large number of people who do not qualify for earnings-based programs, or whose income from all sources is inadequate to maintain a minimum standard of living. The assistance programs that have developed play a vital role in assuring a minimum level of income to the poor and low-income elderly.

Two programs play an especially important role in providing income support to the needy aged—Supplemental Security Income (SSI) and Food Stamps. SSI is a cash assistance program providing monthly benefits to low-income aged, blind, and disabled individuals. The Food Stamps program provides low-income households with monthly coupons for use in the purchase of basic food supplies.

The 5-year period ending in 1985 has witnessed constant debate and a gradual, three-stage evolution of policy governing the Federal role in combating poverty. In the early years of the Reagan administration, the perception—as expressed by the President—that the greedy as well as the needy had become beneficiaries of the safety net of poverty programs gave impetus to a reduction in the scope of the Federal role in poverty programs. In 1981 and 1982, the administration proposed a vast number of legislative and administrative changes designed to implement this philosophy. While Congress rejected many of these proposals, it was clear that Federal policy had undergone major changes.

In 1983 and 1984 however, following a recession and congressional elections, the pace of change slowed dramatically. Any changes that did occur in this period were either minor program changes, or did not directly affect the elderly. In fact, outlays in the SSI actually increased.

In 1985, Congress acted to protect programs for the poor from futher cuts. In the fashioning the Balanced Budget and Emergency Deficit Control Act of 1985, termed the Gramm-Rudman-Hollings Act (Public Law 99–177), Congress specifically excluded SSI and Food Stamps from the automatic cuts that the act imposed. Congress also excluded from the act the Aid to Families with Dependent Children [AFDC] program, the Women, Infants and Children [WIC] nutrition program, and several other poverty programs.

Congressional opposition to spending reductions in low-income assistance has been based on a concern that further cuts would severely affect the deserving poor whom the programs seek to help.

In addition, recent studies indicated that the majority of these deserving poor are women, predominately single heads of households or elderly women living alone, whose poverty results from historic social problems over which these individuals had no control. Congressional resistance to reductions in these programs has been strong enough to dissuade the administration from proposing further substantial cuts in SSI or Food Stamps, although the President has proposed a broad study of Federal welfare programs.

## Chapter 5

# SUPPLEMENTAL SECURITY INCOME [SSI]

### OVERVIEW

1985 saw comparatively little significant congressional activity regarding SSI, in part because Congress has addressed a number of concerns about the SSI Program during 1984, the 10th anniversary of the program. As part of the Deficit Reduction Act of 1984 [DEFRA], most notably, Congress increased the resources test for individuals from $1,500 to $2,000 and for couples from $2,250 to $3,000, phased in over a 5-year period, and limited to 10 percent the amount that SSA could withhold from recipient's benefit checks as a means of recovering overpayments. The passage of the Social Security Disability Benefits Reform Act in 1984 also made a major impact on SSI's standards for determination of disability which are the same as those in the Social Security disability insurance program.

In recent years SSI has escaped the budget-cutting efforts directed at other means-tested programs. This trend continued in 1985, as Congress protected SSI in the fiscal year 1986 Budget and specifically exempted SSI from the automatic budget cuts the Gramm-Rudman-Hollings Act will impose if the Government fails to meet its deficit reduction targets.

### A. BACKGROUND

The Supplemental Security Income [SSI] Program provides a guaranteed minimum income to the Nation's aged, blind, and disabled. Enacted in 1972 as title XVI of the Social Security Act, SSI was designed to establish a uniform, national income floor to insure the economic security of America's most needy and vulnerable groups. Just under 3.9 million people receive benefits from SSI, with maximum Federal monthly benefits in 1986 amounting to $336 for individuals and $504 for couples. SSI is financed through general revenues, and is administered by the Social Security Administration [SSA].

SSI was created to consolidate at the Federal level three State administered public assistance programs—old-age assistance [OAA], aid to the blind [AB], and aid to the permanently and totally disabled [APTD]. Congress intended that Federal financing and administration would:

(1) Simplify administration of welfare and provide fiscal relief to the States.

(2) Provide more adequate, more uniform, and more equitable benefits.

(3) Reduce the stigma of welfare by making payments through SSA and thereby associating SSI with social insurance.

(4) Improve incentives for the poor to seek employment; and

(5) Decrease harassment of recipients by eliminating obstructive eligibility investigations to determine need, and doing away with lien and relative responsibility laws.

After a decade of program operation, the basic structure and purpose of SSI has not changed in any substantial way. Legislation addressing SSI has primarily focused on improving administrative efficiency, increasing intraprogram equity, and protecting former recipients of the State programs from losing benefits due to federalization.

To qualify for SSI, an individual must be 65 or over, blind, or disabled, and demonstrate need for income supplementation. Need is determined through a means test which is an evaluation of income and assets in relation to established maximum standards. In 1986, recipient's unearned income (Social Security and other benefits) cannot exceed by more than $20 the maximum Federal SSI benefit ($336 for individuals, $502 for couples). In addition to meeting the income test, assets may not exceed $1,700 for an individual or $2,550 for couples. However, in calculating assets, the value of a person's home is not counted, nor are the first $4,500 in fair market value for an automobile and the first $2,000 in equity value for household goods and personal effects. Regulations also provide guidelines for determining the countable value of certain other assets, such as burial plots and life insurance policies. Eligibility criteria for SSI are summarized below:

*Basic SSI Eligibility Conditions*

| | |
|---|---|
| Aged | 65 or older. |
| Blind | Vision no better than 20/200 or limited visual field of 20 degrees or less with the best corrective glasses. |
| Disabled | A physical or mental impairment which prevents a person from doing any substantial work and is expected to last at least 12 months or result in death. |
| Resource limits[1] | $1,700 for individuals and $2,550 for couples. |
| Income limits[2] | $336 per month for individuals, and $502 per month for couples. |
| Citizenship | U.S. citizen, immigrant lawfully admitted for permanent residence, or other persons residing in the United States under color of law. |
| Residency | Resident of the United States or the Northern Mariana Islands. |

[1] Not all resources are counted in determining eligibility.

[2] Not all income is counted in determining eligibility. Also, a person may have income above the limit and possibly be eligible for a State supplement only, but the income levels vary among States.

(Note.—Disabled must accept vocational rehabilitation if available. Drug addicts and alcoholics must accept appropriate treatment if available.

## B. ISSUES

### 1. INCOME LIMITS

From a policy perspective, many have criticized the income limits as being too restrictive. The income limit for individuals ($336 a month, or $4,032 a year). Clearly, a large group of people whom the Census Bureau define as living in poverty are not eligible for SSI.

Second, the law requires that gifts or inheritances, which may not be readily converted into cash, be treated as income in the month they are received. For instance, if an elderly SSI recipient is given a portable radio by her granddaughter, or inherits a kitchen table from a brother who died, she must report receipt of these gifts to SSSA, and their value will be subtracted from here SSI check. Many have criticized this treatment of gifts as income as a disincentive to family and community involvement in meeting the needs of SSI recipients.

### 2. ASSETS LIMITS

Assets limits have increased only slightly since 1974, despite a 119-percent increase in the Consumer Price Index [CPI] over the same period. Today, it would take almost $3,000 and $5,000, respectively, to purchase what $1,500 and $2,250 could purchase in January 1974. Even considering 1984 changes which will gradually raise asset limits to $2,000 for individuals and $3,000 for couples by 1989, the fact that these limits remained the same for a decade, and have only recently been increased in small increments, represents a serious deterioration of the adequacy of SSI.

A specific problem associated with the SSI assets test is that it is an all-or-nothing cutoff, or "cliff" in which small differences cause individuals to be either fully eligible or ineligible. Currently, if a recipient goes over the limit even a small amount, perhaps from interest in a bank account, that person is deemed ineligible for SSI in the month or months in which there is an excess. This ineligibility usually leads to substantial overpayments, due to the fact that the errors usually are detected only after the full benefits have been paid to the recipient. Prior to 1985, if an SSI beneficiary exceeded the assets limit by $10, that individual's total benefit was eliminated; rather than reduced $10. 1984 legislation however, limited the amount of recovery of overpayments to the amount by which the resource limit was exceeded, in cases where the excess was less than $50.

This problem was exacerbated by SSA's recent policy of aggressively recovering overpayments, and rarely waiving the obligation to pay back to SSA the funds overpayed. At present approximately 20 percent of all overpayment errors in SSI result from problems associated with bank accounts. Significantly, these errors account for about 50 percent of the dollar amount to be collected as overpayments.

Though there are significant problems with the assets test, many argue that it serves a critical purpose in ensuring that only people with few or no resources receive benefits, and that eliminating the test would create more problems than it would resolve. For instance, outright elimination of the assets test might open the program to those with limited income, but significant resources that might otherwise be converted to cash that could be used for self-support. Other than eliminating it altogether, there are a number of methods of revising the assets test. Congress could limit the type of assets which are included in the test, eliminating the value of insurance policies, for instance.

Alternatively, Congress could fold the evaluation of assets into an expanded income test, where assets are translated into an "income stream" over time. Assets would be totaled, and then coverted into a stream of cash income, using a set of specific actuarial assumptions (such as life expectancy tables, projected interest rates) to make the calculation. Under the current structure, it is assumed an individual will consume available assets until they drop below the SSI threshold; at that point, income supplementation will begin. Under a plan to annuitize the value of assets, an individual would receive SSI income supplementation while spending down his or her resources over time. This would eliminate the problem of an arbitrary cutoff point for people who are cash poor, but happen to have some available resources. A major problem with this approach is the difficulty of designing the basic assumptions that would guide the valuation of assets over time. Further, such a change could be costly by allowing a large number of presently ineligible individuals to qualify for benefits.

### 3. BENEFITS

Criticism of the benefit structure in SSI has focused recently on the one-third reduction rule for recipients living in the home of another, and the personal needs allowance for institutionalized recipients. In January 1986, the maximum Federal monthly payment is $336 for an eligible individual and $502 for an eligible couple. The law requires a benefit reduction of one-third for those who live in another person's household and who receive support and maintenance from that person or persons. Many groups, including the 1981 National Commission on Social Security, have recommended that the one-third reduction be eliminated. It is very complex provision to administer, and it serves as a disincentive to SSI beneficiaries to live with others. It may be counterproductive to discourage SSI recipients with mental and physical disadvantages from living with others who may be able to provide support.

Persons who reside in public institutions are usually ineligible for SSI benefits. However, if a person lives in a community care facility serving no moe than 16 people, that individual can often receive SSI benefits. Residents of larger health care institutions in which Medicaid is paying for more than half of that individual's care are eligible for a maximum $25 monthly SSI benefit, which is intended to cover personal confort items.

Two problems emerge in the area of SSI benefits for those living in institutions.

First, the 16-person limit for community care excludes residents of shelters for the homeless, and larger, shared housing arrangements for mentally impaired individuals who need assistance in daily living.

Second, the $25 personal needs allowance for residents of nursing homes has not been changed since 1974. With the inflation that has occurred in the past decade, the value of this monthly allowance has substantially eroded. Many advocates have begun calling for an increase in the personal need allowance, claiming that this group deserves inflation-protected benefits.

## 4. PARTICIPATION

Despite initial projections that over 7 million Americans would participate in SSI, the total SSI caseload has never exceeded 4.5 million. Early assumptions that over 90 percent of the eligible population would benefit from SSI were proven too optimistic; in reality, a conservative estimate of the participation rate is closer to 60 percent.

These low levels of participation are difficult to explain. Few surveys of the attitudes and opinions of the SSI population have been undertaken, and alternative interpretations of the problem have often been based upon anecdotal information.

Typical explanations of low participation rates in SSI among the elderly include: (a) The stigma associated with welfare; (b) very small benefit amounts for many who near the maximum income and resource limits; (c) barriers of literacy, mental and physical handicap, and access to transportation; (d) SSI's administrative complexity, which requires a great deal of effort on the part of participants.

## 5. ELIGIBILITY OF SSI RECIPIENTS FOR OTHER PUBLIC ASSISTANCE PROGRAMS

SSI recipients often qualify for additional Federal public assistance from a variety of programs, most notably Medicaid and food stamps. The relationship between SSI and food stamps has changed over the last decade. Originally, SSI beneficiaries were prevented by the statute from receiving food stamps. This exclusion was eliminated in 1977 by Congress, by virtue of the fact that it seemed inequitable that AFDC recipients, as well as people whose income or assets exceeded SSI limits, could qualify for Food Stamps while SSI beneficiaries could not. Currently, SSI recipients can apply for food stamps in SSA district offices, where eligibility determinations are made in accordance with conventional food stamp guidelines. In California and Wisconsin, food stamps are "cashed out," or converted into cash as part of monthly SSI payments.

States are required to offer Medicaid to SSI recipients if the recipients are eligible under the State's 1972 eligibility criteria. The 1972 legislation creating SSI gave States the option of allowing SSA to determine Medicaid eligibility, if the States were willing to accept SSI eligibility as a condition for Medicaid coverage. Currently, more than half the States allow SSA to execute Medicaid determinations for SSI recipients. Medicaid is perhaps the most valuable ancillary Federal program for SSI beneficiaries, and adds significantly to the adequacy of SSI coverage.

Medicaid is often more important to many SSI recipients than cash benefits, and there are a number of instances in which small increases in outside income, and corresponding ineligibility for SSI, will cause the loss of Medicaid benefits. For instance, a 60-year-old woman may become eligible for Social Security widow's benefits and concurrently loss eligibility for SSI and Medicaid, while not becoming eligible for Medicare. The loss of Medicaid often far outweighs the increase in cash benefits to these individuals.

Another area of concern is the effect of assistance provided by private nonprofit organizations to SSI recipients (for example, free food from soup kitchens, subsidized electricity) on their eligibility. Advocates argue that such assistance should be excluded from countable income, particularly because it serves the emergency needs of many very low-income recipients. Also, counting this aid as income discourages charitable involvement in providing for the poor. Opponents of this policy point out that SSI is a strict, means-tested program, and to the extent that applicants or recipients have available means, whether earned or provided for free, they should be evaluated against the objective standards that limit eligibility for benefits.

### 6. EMPLOYMENT AND REHABILITATION FOR SSI RECIPIENTS

One of the foundational objectives of SSI was to create a welfare program that had the least possible disincentives to employment. At no time, however, has more than a tiny fraction of the SSI caseload received income from earnings (in December 1983, for instance, only 3.3 percent of all recipients reported earnings).

This low rate of employment is a product of a number of factors. First, SSI recipients under age 65 are by definition severely disabled, and it is difficult to find employers willing to hire them and take care of their special mental and physical needs. Second, there are major work disincentives built into the structure of SSI. For instance, an individual may be able to secure earnings that are more advantageous than the SSI benefit, but the loss of Medicaid coverage and the difficulty of getting employer-sponsored health insurance, more than offsets the increased income.

The Social Security Disability Amendments of 1980 [Public Law 96-265], included changes that were meant to encourage SSI recipients to seek and engage in employment. The relevant provisions, which became section 1619 of the Social Security Act, were designed to lessen the substantial disincentives to work in SSI. They include: (a) Special monthly benefits, as well as Medicaid eligibility, will continue for disabled recipients who have completed the 9-month trial work period and continue to receive earnings in excess of SSI income limits; (b) impairment-related work expenses (including medication, attendant care, special equipment) can now be deducted from countable income; and (c) money earned in sheltered workshops is now treated as earned, rather than unearned income for the purpose of calculating benefits.

The law limited these provisions to a temporary, 3-year trial period that expired on December 31, 1983. They were extended another 3 years in 1984, with the passage of the Social Security Disability Benefits Reform Act. Though definitive statistics are unavailable, it is estimated that between 400 and 500 people receive special SSI benefits and 5,000 to 6,000 recipients take advantage of the extended Medicaid benefits.

The relatively low level of utilization of these special benefits offered by the 1980 amendments appears to be a product of widespread unawareness of the existence of the provisions and of the fact that employment will not automatically terminate eligibility for SSI and Medicaid.

### 7. ADMINISTRATIVE ISSUES

One of the original assumptions justifying the creation of SSI was the notion that administration by SSA would eliminate the harassment and stigma associated with traditional, locally run welfare programs. Though SSA has eliminated some of the most embarrassing aspects of receiving welfare—such as lien and relative responsibility requirements—critics have charged that some administrative policies have created problems for recipients in the past few years.

SSA's recent policy of collecting overpayments is perhaps the most extreme example of an insensitive approach to beneficiaries. Beginning in 1981, SSA launched a set of initiatives to increase their collection of SSI overpayments as part of a major governmentwide effort to improve Federal debt management. As part of this effort, administrative instructions were revised to replace the previous policy of withholding no more than 25 percent of a monthly check with a policy of withholding 100-percent of subsequent checks until the overpayment was recouped.

1984 legislation limited recovery of overpayments to no more than 100 percent of a beneficiary's check, but the negative impression of Government harassment of recipients will likey linger for some time.

In addition to the policy of withholding 100 percent of monthly checks to recover overpayments, SSA also instituted a policy of limiting waivers of overpayments. SSA also proposed new rules in February 1983 to limit the rights of recipients to request a waiver of an overpayment to within 60 days of the notification of the overpayments. These proposed rules never became final regulations, due to public opposition. Nonetheless, the proposed regulations, like the policy of 100-percent withholding, represent a change in attitude about the needs of the SSI population, and the basic mission of the agency.

## C. SSI LEGISLATION

The most significant legislative action concerning SSI was the decision to exclude the program from the list of automatic program cuts which would take effect under the Gramm-Rudman-Hollings Act if the Government did not meet its deficit reduction targets. While this action shows the concern of Congress to preserve a major feature of the safety net of social programs which protects the Nation's disadvantaged citizens, it does not protect the program from other cuts. The automatic cuts do not go into effect unless Congress fails to reduce the deficit on its own, and there is no guarantee that the pressure to reduce the deficit will not affect SSI.

With the exception of the exclusion of SSI from budget cutting measures, 1985 saw very little legislative action involving SSI. One bill, H.R. 2173, which was introduced by Representative Evans, would increase the personal needs allowance from $25 to $50 per month, and provide yearly COLA's as well. No action was taken on this bill however.

## D. PROGNOSIS FOR 1986

Throughout its 11-year history, SSI has been considered an essential element of the safety net of programs which protect the Nation's least advantaged citizens. This role has protected the program from major cuts in recent years and, in fact, led to an increase in the payment standard in 1983 and enactment of a few overdue reforms in 1984. Nonetheless, budget pressure has kept the program from expanding and from receiving, in some cases, necessary adjustment levels to accommodate inflation. The decision to exclude SSI from the automatic budget cuts of Gramm-Rudman-Hollings indicates that Congress intends to continue to protect the SSI program. However, pressure on the Federal budget will most likely prevent growth of the program in the near future. Nonetheless, advocates of the program can be expected to continue attempts in 1986 to increase the personal needs allowance and to improve access to the program.

# Chapter 6

# FOOD STAMPS

## OVERVIEW

During 1985, the debate on the Food Stamp Program centered on what revisions to make in extending authorization of the program's appropriations beyond fiscal year 1985. As in 1984, when a major rewrite of the Food Stamp Act died at the end of the 98th Congress after approval by the House of Representatives (H.R. 5151, the Hunger Relief Act of 1984), the issues of particular interest to Congress were the accessibility of the program to the eligible population, the adequacy of the benefits provided, the need for work and training programs for employable recipients, and the degree to which States should assume responsibility for program costs and administration.

At the end of 1985, Congress and the President approved a new "farm bill," the Food Security Act of 1985 (Public Law 99-198), which extended the authorization for food stamp appropriations for 5 years with dollars limits on appropriations that rise from $13 billion in 1986 to $16 billion in 1990. The food stamp provisions of the Food Security Act also made a number of changes in the program that, over the next 5 years, are expected to add about $800 million in new food stamp spending and increase funding for Puerto Rico's special nutrition assistance block grant (operated in place of food stamps) by nearly $300 million.

In addition to the changes enacted in the 1985 farm bill, Congress appropriated $12.7 billion to fund the program (including $825 million for Puerto Rico's block grant) for fiscal year 1986, and chose to exempt food stamp programs from any automatic spending reductions required under the Balanced Budget and Emergency Deficit Control Act of 1985 (the so-called "Gramm-Rudman-Hollings" measure). Funding for the fiscal year 1985 year program was boosted with a $300 million supplemental appropriation, bringing total 1985 food stamp appropriations to $12.6 billion.

## A. BACKGROUND

The Food Stamp Program provides a uniform national benefit floor in the form of enough food stamps for a nutritionally adequate diet, when combined with income available to the recipient household. The program is available everywhere and to everyone in equal need and is responsive to shifts in unemployment and to personal economic tragedy. The purpose of the program is to provide a means of obtaining a more nutritious diet when available income makes that impossible—and there is ample evidence that it has been successful.

The tremendous importance of the Food Stamp Program, especially to the elderly and to children, has recently been underscored by new studies that confirm that there is a direct connection between nutritional status and health. The Food Stamp Program has some special rules for the elderly—including more liberal treatment of shelter expenses, medical expenses, and assets. The program, for example, recognizes that elderly people with high medical bills may have total incomes higher than the poverty line, but no more money actually available for food than those with lower incomes and no medical bills. Yet, in 1985, persons aged 60 or more were estimated to account for only 8.5 percent of the 21 million food stamp participants. In contrast, in 1985, the proportion of elderly below the poverty level is 15 percent.

The Food Stamp Program began as a group of pilot projects set up by Executive Order in 1961 when the Federal Government began a small, experimental antihunger program in eight U.S. counties. As a result of the pilot projects, today's Food Stamp Program was authorized by the Food Stamp Act of 1964, which offered States the option of operating a Food Stamp Program in lieu of existing commodity donation programs. In 1977 the Congress enacted the Food Stamp Act of 1977, which completely revamped the Food Stamp Program's operation. Since then, various amendments have been enacted to improve the program and strengthen its integrity.

The Food Stamp Program is designed to help low-income households obtain more nutritious diets. Eligible applicants receive food coupons to buy food through normal market channels, primarily grocery stores. In addition to making food assistance available to eligible groups of people who, for one reason or another have difficulty meeting their nutritional needs themselves, the Food Stamp Program also serves as an income security program by supplementing available family income, contributes to farm and retail food sales, and reduces surplus stocks.

The Federal Government bears the cost of all food stamp benefits and shares, with the States and localities, 50 percent of most administrative costs. State and local costs associated with computerization and fraud control activities are eligible for 75 percent Federal funding. The Food and Nutrition Service of the Department of Agriculture is responsible for administering and supervising the Food Stamp Program and for developing program policies and regulations. At the State and local levels, the Food Stamp Program is administered by State welfare departments.

The Secretary of Agriculture has established uniform national standards of eligibility for a household's participation in the program. Basically, all households must meet a liquid assets test and, except for those with an elderly or disabled member, must meet a two-tiered income test to be eligible for benefits. The household's monthly gross income must not exceed 130 percent of the income poverty levels set by the Office of Management and Budget, and its monthly net income (after deducting amounts for such things as medical and dependent care, shelter, utilities, and work-related expenses) must be equal to or less than 100 percent of the OMB poverty levels.

Applicant households that are certified as eligible are entitled to a specific level of benefits—generally in the form of food coupons, which are accepted by authorized food stores in exchange for food. The level of benefits is based on USDA's Thrifty Food Plan, which estimates how much it would cost a household that shops economically to meet its nutritional needs. Because a food stamp household is expected to spend 30 percent of its disposable income for food, the food stamp benefit equals the amount by which the Thrifty Food Plan exceeds 30 percent of the household's net income. In 1986, its maximum benefit to a one-person household is $80 a month and for a two-person household, the maximum is $147 a month.

## B. ISSUES

During 1985, debate in Congress focused on whether the program has been cut too far, and needs to be expanded, or whether further savings in the program are justified. Framing this debate are alternative assumptions about the extent of hunger in the United States, and the role and adequacy of food stamps in combating it.

### 1. THE HUNGER DEBATE

The first major publicity about hunger in America came after a visit to the rural South in April 1967 by Members of the Senate Subcommittee on Employment, Manpower and Poverty to hold hearings on the effectiveness of the War on Poverty. They were told of hunger and poverty. Later that year, a team of physicians found severe nutritional problems in various areas of the country. These and other reports of hunger and malnutrition in America led to an expansion of Federal food assistance programs. When the physicians returned in 1977 to evaluate progress made in combating hunger, they found dramatic improvements in nutritional status in those same areas. The improvement was attributed to the expansion of Federal food programs in the 1970's. Many believe that the food stamp program ranks as one of the most effective efforts to combat hunger and poverty in recent years.

Over the last few years, considerable media attention has been focused on the re-emergence of hunger in the United States. In 1981, news accounts of bread lines and crowded soup kitchens began to appear in papers in various cities of the country. In October 1982, the U.S. Conference of Mayors reported that in most of their cities surveyed, the need for food represented a most serious emergency. In June of 1983, the Conference issued a report entitled "Hunger in American Cities" in which they reported a dramatic increase in hunger in the cities of the Nation. Closely following that report, the General Accounting Office reported widespread and growing hunger in America and found that persons in need of food include both those left out of Government nutrition programs as well as those for whom assistance is simply not enough on which to live. In December 1983, Senator Edward Kennedy issued, to the Senate Committee on Labor and Human Resources, a report entitled "Going Hungry in America." Based on a field investigation undertaken the week before Thanksgiving 1983, Senator Kennedy's report found that hunger was on the rise in America, and that Congress must act to improve assistance to the hungry.

The Kennedy report contained seven suggestions for change in the food stamp program, with an estimated annual Federal cost of $2 billion. The intent of the recommendations made in the report was to restore several of the major food stamp budget cuts legislated in 1981–82, and to significantly increase basic food stamp benefits. Senator Kennedy's major proposal would restore the 1-percent allotment reduction legislation in 1982 and add a 10-percent benefit increase to take into account that existing food stamp benefits, even at 100 percent of the thrifty food plan, do not allow for the purchase of an adequate diet in the face of transportation difficulties, price variations, limited nutritional education, and other limits that reduce a family's ability to purchase food. Critics of the report opposed the substantial cost involved in the recommendations and pointed out that the food stamp program is designed to supplement a household's food-buying power and cannot be expected to bear the burden of correcting for other nonfood-related problems.

In August 1983, to investigate the allegations of rampant hunger in the United States, the President appointed a commission to study the problem. At the end of 1984, the President's Task Force on Food Assistance released its report to Congress and to the public. Although the report acknowledged pockets of hunger, it asserted that there was little evidence of widespread hunger in the United States and that reduction in Federal spending for food assistance had not injured the poor. Several modest recommendations to make the food stamp program more accessible to the hungry were included in the report. These included: Liberalized rules governing liquid assets and car ownership, targeted benefit increases to beneficiaries with high medical or shelter expenses (particularly the elderly and disabled), automatic food stamp eligibility for cash welfare recipients, and modification of the permanent residence requirement so that benefits are available to the homeless. These liberalizations, however, were offset by cost-reduction measures which included: Increasing the State responsibility for erroneous payments and an optional State block grant for food assistance. The task force recommendations were heralded by some as a means of restoring full benefits, opening up the program to the new poor (recently unemployed), lessening administrative burdens, and increasing participation among groups in particular need. Critics, however, contended that the task force recommendations did not go far enough in restoring budget reductions previously enacted.

Results of 15 months of research on the problem of hunger in New England, by staff at the Harvard School of Public Health, concluded in 1984, revealed that: (1) Substantial hunger exists in every State in the region; (2) hunger is far more widespread than has generally been realized; and (3) hunger in the region has been growing at a steady pace for at least 3 years, and presently shows no sign of diminishing. The researchers found elderly who are frequenting emergency food programs in greater numbers and that the elderly often suffer in the privacy of their homes, either because it is more difficult for them to get around or because they choose to tolerate their suffering alone, no longer having young children to prompt them to leave their home for food. The doctors also expressed concern over what physicians had noted in their clinical practices; apparently increasing numbers of malnourished children and greater hunger among their patients, including the elderly. They also cited the impact of malnutrition on health and stated that children and elderly people are likely to suffer the greatest harm when food is inadequate.

More recently, a January 1986 follow-up study by the Harvard University School of Public Health's Physician Task Force on Hunger in America, found that food stamps reach less than one-third of the people eligible to receive them in 150 counties across the country. Researchers for the group said that this indicates that hunger is common in many counties across the South, Mid-West, and West. The researchers compared census reports on the number of families under the poverty level with figures on the number of people who receive food stamps. They found that, nationally, the proportion of those eligible to receive them, and those who actually got them, had dropped to 55 percent in 1984 from 65 percent in 1980 and concluded that hunger is increasing as a problem. They also stated that Federal food programs designed to feed the hungry have been weakened and cited as a chief factor, the failure of the Food Stamp Program to reach many people who need its benefits. The Assistant Secretary of Agriculture in charge of the Food Stamp Program disputed the findings, saying that the program served 80 percent of those eligible and that the problem had been overstated because the researchers ignored the seasonal nature of the aid and by improperly equating poverty with hunger.

According to medical experts on aging, malnutrition may account for a substantially greater portion of illness among elderly Americans than has long been assumed. The concern about malnutrition is rising fast as the numbers of elderly climb and as surveys reveal how poorly millions of them eat. The New York Times reported, in August 1985, that scientists now estimate that anywhere from 15 percent to 50 percent of Americans over the age of 65 consume too few calories, proteins, or essential vitamins and minerals for good health. According to the article, gerontologists are becoming alarmed by evidence that malnourishment may cause much of the physiological decline in disease resistance seen in elderly patients—a weakening of immunological defenses that has commonly been blamed on the aging process. Experts say that many elderly people fall into a spiral of undereating, illness, physical inactivity, and depression. The recent findings suggest that much illness among the elderly could have been prevented through more aggressive nutritional aid. In the view of some physicians, immunological studies hold out the promise that many individuals can lighten the disease burden of old age by eating better. Low participation in the food stamp program leaves large numbers of Americans without enough to eat and the problems exist largely because many people who are eligible for food stamps are not receiving them.

In an April 1985 report on the Food Stamp Program, the General Accounting Office stated that research conducted by private organizations and the U.S. Department of Agriculture (USDA), as well as the President's Task Force on Food Assistance, indicates that many low-income households are not participating in the Food Stamp Program. The GAO said that research studies attributed nonparticipation to such factors as: (1) A lack of information regarding eligibility, (2) the amount of potential aid not being enough to warrant the time and effort to apply, (3) administrative requirements, such as complex application forms and required documentation, (4) physical access problems, such as transportation or the physical condition of the potentially eligible applicant, and (5) attitudinal factors, such as households being sensitive to the social stigma associated with receiving food assistance. Others may feel that they do not need or want Federal food assistance. One study estimated that only 48 percent of eligible elderly received food stamp benefits in 1980 and 1981.

Participation was especially low among single elderly individuals, and the older a person was, the less likely he or she was to participate. The author analyzed why eligible elderly persons did not participate in the Food Stamp Program and found that 33 percent of eligible nonparticipants indicated that they did not think they were eligible for food stamps, and another 36 percent said that they did not know whether they were eligible.

### 2. Reorganization of the Food Stamp Program

The Food Stamp Program is one of the largest and probably the most visible of all Government support programs. It has also been one of the most popular targets of troubled taxpayers and politicians aiming to reduce the size of government. To opponents, food stamps are a classic case of runaway Federal programs—growing from 11.3 million persons in 1971 to 22 million in 1981. Critics label it an income-transfer program unrelated to nutritional needs. It has also been denounced as a breeding ground for fraud and abuse, such as by students and those owning luxury cars and vacation homes. Supporters of food stamps say that it is one of the most effective efforts to combat hunger and poverty in recent years. The food stamp rolls have swelled, they say, not because recipients are abusing the program but because a deteriorating economy (unemployment and inflation) has made more Americans dependent on outside aid.

Many of the criticisms of the Food Stamp Program have taken effect and since 1981, the Food Stamp Program has been the source of substantial budget savings due to cuts enacted by Congress and administrative changes executed by the administration to limit abuse of the program. Overall, the Congressional Budget Office [CBO] has estimated that legislative measures taken in 1981 and 1982 held food stamp spending for fiscal years 1982 through 1985 nearly $7 billion below what would have been spent under pre-1981 law. This translated into a 13-percent reduction at a time when poverty was at its highest level in nearly two decades. For most recipients, the changes did not lead to a direct reduction in benefits. Rather, they delayed or lowered benefit increases scheduled under previous law. About 1 million people, however, lost eligibility for food stamps due to changes in law, and some recipients received reduced benefits due to administrative changes.

#### (A) THE GRACE COMMISSION

Throughout the spring of 1983, the Agriculture Department task force of the Grace Commission issued a series of recommendations for changes in the Food Stamp Program that could achieve significant savings. They were not official administrative proposals, and did not seriously enter congressional deliberations over the potential budget reduction initiatives for the Food Stamp Program. Because of the continued pressure to reduce the Federal deficit, however, such recommendations could be revived. The Grace Commission effort was part of a governmentwide set of task force reviews focused on producing new ideas for cost control. Other Commission suggestions affecting multiple programs, including food stamps, would increase the use of IRS information in verifying recipient income and assets and allow tax refunds to be intercepted to repay overissued benefits.

The major recommendation of the Grace Commission task force was to revise the method by which food stamp allotment levels are established. The recommendation would require that the age, sex, and household size composition be considered in choosing the appropriate thrifty food plan amount on which to base benefits. Revising the thrifty food plan used for establishing food stamp benefit levels was put forward with the justification that food stamp benefit levels should reflect the composition of the population served. Critics of this change argue that adequate diets are very difficult to achieve using the current benefit levels, and would be much more so with the reduced levels that would result for small households from the recommended revisions.

The other major recommendation of the Grace Commission would require that the value of the Federal subsidy in school lunches and meals provided in other federally supported child nutrition programs be counted as income to a food stamp household receiving them, thereby increasing the households counted income and reducing its food stamp benefits to the extent it participates in child nutrition programs. At present, the Food Stamp Program counts only cash income received directly. Counting Federal child nutrition subsidies as income was advanced as a way of eliminating program duplication. It would, however, reduce what are seen by some as already inadequate benefits to families with children, and add administrative burdens and potential new inequities to the Food Stamp Program.

### (B) THE ADMINISTRATION'S 1985 PROPOSALS

From the time he took office, President Reagan promised to tighten enforcement of the Food Stamp Program. Most of his budget proposals, however, focus on ways to reduce benefits and eligibility. In its fiscal year 1986 budget submission, presented to Congress in 1985, the administration proposed three significant, and several minor, changes in the Food Stamp Act. It estimated that, if enacted, the changes could achieve net budget savings of about $60 million in fiscal year 1986 and larger savings in later years, totaling nearly $500 million over the next 3 years. Appropriations for food stamps were proposed to be reauthorized for 4 years, through 1989, with limits on each year's appropriations ranging from $13 to $14.5 billion. Only a few limited benefit reductions were proposed by the administration, with only one having a potential effect on the elderly (changes in the treatment of food stamp recipients also receiving benefits under the Low-Income Home Energy Assistance Act). The majority of the cost savings were to come from shifting some costs to the States and establishment of "workfare" programs for employable recipients. The most significant administration proposals, however, were not taken up by Congress in its 1985 food stamp considerations.

The major administration proposal was to allow States to operate food assistance programs of their own design with a block grant of Federal funds, rather than offering only the Food Stamp Program. A second proposal would have changed Federal funding for State and local administrative expenses into a block grant. The third significant proposal would have required all States to operate workfare programs for employable food stamp recipients. Among the less notable proposals, a few would have resulted in some benefit reductions—e.g., recommendations to count income received by participants in Job Training Partnership Act programs and to limit food stamp benefits for recipients also receiving aid under the Low-Income Energy Assistance Act. These latter provisions were debated and decided by Congress during its deliberations on the farm bill.

### *(1) State Block Grant*

The Food Stamp Program is optional with the States; they decide whether or not to participate. If a State, however, does not operate the Food Stamp Program, no alternative source of Federal support for general nutrition assistance to low-income households is available. The Commonwealth of Puerto Rico was removed from the Food Stamp Program, per se, in 1982 and given an $825 million a year block grant that it now uses to fund a cash nutrition aid program.

The Administration proposed to allow States to withdraw from the regular Food Stamp Program, take a "block grant" of money based on Federal food stamp spending in the State in the previous year, and use the money to operate a food assistance program of their own design for low-income persons. After the first year, a State's nutrition assistance block grant amount was to be adjusted to reflect changes in food prices, unemployment, and other factors that might affect the need for food aid.

The administration said it advanced this proposal in order to allow States to experiment with potentially more effective and efficient approaches to nutrition assistance, and pointed to a similar recommendation by the 1983-84 President's Task Force on Food Assistance. The adjustable nature of the block grant was intended to ensure, as much as possible, that States did not suffer financially from having chosen to take a block grant rather than continuing to rely on food stamps. Supporters of the block grant concept argue that welfare programs should recognize different community perceptions of need and different standards of living; leaving the decisionmaking to State and local authorities. Moreover, it is argued, turning food aid responsibility over to the States and localities would make for a more accountable program, in that States and localities would have a fiscal stake in the program to encourage better administration.

Critics protested that opting States, under pressure to keep spending within the block grant amount, might be unable to respond adequately to increases in need, given the limited adjustability of block grants. They were also concerned that the broad coverage of low-income households of all types, and the extensive recipient protections built into the Federal Food Stamp Program might be abrogated by States seeking to control expenditures. Some feared that States would opt for a block grant simply to void fiscal penalties for high rates of error in operating the regular Food Stamp Program. Finally, some saw it as the first step away from a national minimum welfare commitment. Turning over responsibility for food assistance to the States would mean the abandonment of what are, in essence, the only set of nationally uniform minimum welfare standards. With its federally established benefit, eligibility, and administrative standards, the Food Stamp Program, has provided an important supplement to what some see as inadequate cash assistance in many States. It tended to equalize treatment of, and government benefits to, low-income persons, and helped liberalize what some perceive as unnecessarily harsh State and local administrative practices in welfare programs.

Given the additional cost and administrative burden of running a separate food aid program, and the substantial overlap between the food stamp population and recipients of other forms of aid, especially cash assistance, it seems probable that turnover of food assistance responsibility to the States would mean the end of food stamps as a separate form of low-income aid and its replacement with re-worked State cash assistance systems. Many maintain, however, that food stamps, earmarked only for food purchases, have substantially reduced the observed level of malnutrition in the country since the program began its expansion in 1971. Doctors and other observers with the 1967–68 Citizens Board of Inquiry on Hunger and Malnutrition returned to the poverty regions they visited in the late 1960's and found marked improvement and substantially increased food spending, suggesting that food aid programs may be one of the most effective anti-poverty efforts of the last 15 years.

### *(2) Administrative Expense Block Grants*

While food stamp benefits are paid entirely by the Federal Government, administrative expenses are shared by the Federal Government and States (and, in some cases, localities). The Federal Government pays for all of its own administrative expenses, and between 50 and 75 percent of State and local costs (depending on the type of cost), without any upper limit.

The administration proposed that a flat amount of $840 million be appropriated in fiscal year 1986 to cover the Federal share of State and local administrative expenses. This amount was roughly equal to the amount paid to States in fiscal year 1985 to match expenses under the 50–75 percent matching rule, and was to be increased in the future to take inflation into account. If a State's administrative expenses ran higher than its share of the administrative cost block grant, it would be responsible for the full cost of the coverage.

The administration said that "block-granting" the Federal share of State and local administrative expenses was desirable because: It would remove excessive reporting and accounting requirements needed to justify States' claims for Federal reimbursement; would control future Federal costs by limiting escalation to inflation adjustments only; and would provide an incentive for States to control administrative costs since Federal sharing would not automatically respond to State-specific increases.

While recognizing the liberality of an indexed block grant system, opponents viewed the administration's proposal with concern because they felt it would lock into place current State shares and, in doing so, remove flexibility to respond to substantial caseload increases, perhaps result in reduced levels of service, and remove incentives to improve services. They also objected to the arbitrary choice of a base year (1985), maintaining that, depending on how unusual that year was for a given State, it might receive a windfall or be penalized under the block grant system.

### *(3) Workfare*

States and localities may choose to operate food stamp workfare programs under which unemployed or underemployed able-bodied adult recipients not caring for young children (or disabled) are required to "work off" their household's food stamp benefit in a public service job assigned by the administering welfare agency. The number of hours of work is determined by dividing the household's monthly benefit by the minimum wage. Under this optional system, only a very few jurisdictions operate food stamp workfare programs.

The administration proposed to require all jurisdictions operating the Food Stamp Program to run a workfare program for recipients (sometimes called a community work experience program or CWEP). The proposal to require workfare was recommended as a method to control abuse of the program by those who are able but unwilling to work, and to get needed public service jobs done. It is also seen as a way to improve the image of the Food Stamp Program and increase public support for it, along with benefiting recipients by giving them work experience.

Opponents noted the significant administrative costs of operating workfare programs, potential difficulties in finding an adequate number of workfare assignments, and the lack of response to the present optional authority. They also question whether the benefit savings would outweigh administrative and support costs, contending that the existing system has not been given a chance to demonstrate the effectiveness (and possible flaws) of workfare, and noting that much of the cost of workfare would fall on the States while the Federal Government alone would reap benefit savings if recipients left food stamp rolls due to workfare requirements.

## C. LEGISLATION

### 1. House Consideration

In September 1985, the House Committee on Agriculture reported its 1985 farm bill (H.R. 2100), including a 5-year extension of the appropriations authorization for food stamps, with dollar limits on annual appropriations rising from $13.6 billion in 1986 to $17 billion in 1990. Also included were a large number of revisions to the program, having an estimated cost of about $2 billion over the next 5 years.

### 2. SENATE CONSIDERATION

At the end of September 1985, the Senate Committee on Agriculture, Nutrition and Forestry reported its version of a 1985 farm bill (S. 1714), including a 4-year extension of the appropriations authorization for food stamps, with dollar limits on annual appropriations rising from $13 billion in 1986 to $14.7 billion in 1989. Also included were revisions in the program expected to result in estimated savings of up to $900 million over the next 4 years. In November 1985, the full Senate approved its version of the farm bill, including amendments to the committee's food stamp recommendations.

### 3. THE FOOD SECURITY ACT OF 1985

In late December 1985, the House and Senate reached agreement on a farm bill, and the Food Security Act of 1985 was enacted into law (Public Law 99-198) on December 23, 1985. Title XV of the act extends the food stamp appropriations authorization for 5 years, through fiscal year 1990, with dollar limits on appropriations ranging from $13 billion (1986) to $16 billion (1990). It also makes changes in the program that are expected to add about $800 million in new food stamp spending over the next 5 years, plus nearly $300 million to the current $825-million-a-year nutrition assistance block for Puerto Rico.

Substantial changes affecting the elderly that are retained, in whole or in part, from those proposed by the House and Senate include:

—automatic food stamp eligibility for AFDC and SSI households (without any special income limit as proposed by the Senate, but not including SSI recipients in California and Wisconsin);

—an increase in the liquid assets limitation for single-person elderly households, from $1,500 to $3,000 (the existing $3,000 limit for households of two or more with an elderly member is not changed, and the limit for nonelderly households is increased from $1,500 to $2,000);

—reinforcement of requirements for food stamp services at Social Security offices;

—expansion of the number of pilot projects allowing the use of simplified application and standardized benefit procedures for AFDC, SSI, and Medicaid recipients; and

—extension of pilot projects for cash payment of food stamp benefits for the elderly.

A number of other new initiatives, benefit increases, and eligibility liberalizations are also retained in the final Act:

—a requirement for States to establish employment and training programs for employable recipients, with performance standards set by the Federal Government;

—a prohibition on the collection of sales taxes on food stamp purchases;

—an increase in the earned income deduction from 18 to 20 percent;

—an increase in the degree to which high shelter expenses and dependent-care costs are taken into account in food stamp benefit computations;

—an expansion of the definition of disabled person;

—more liberal treatment for households with self-employment income;

—liberalization of the rules governing disqualification for failure to meet work requirements;

—liberalization of student eligibility rules;

—a 6-month moratorium on collection of fiscal sanctions from States, coupled with a study of the food stamp quality control system and revision of the system based on the study's results; and

—increases in the nutrition assistance block grant for Puerto Rico.

Benefit reductions contained in the act are:

—earnings received by on-the-job trainees under Job Training Partnership Act programs will be counted as

—income for food stamp purposes, except in the case of dependents under age 19;

—most rules which disregard the portion of education aid not paid for tuition and mandatory fees (i.e., available for living expenses) will be removed;

—most rules which disregard the portion of cash welfare grants diverted through third parties will be removed; and

—in some few cases, those food stamps recipients who also get aid under the Low-Income Home Energy Assistance Act may have limits placed on the extent to which they can reduce their countable income due to utility expenses.

The major issues resolved in the final House-Senate agreement involved the degree to which benefit increases and eligibility liberalizations proposed by the House should be included and what limits to place on the benefit reduction provisions included in both the House and Senate recommendations. The final agreement on the food stamp provisions in the Food Security Act was largely patterned after the suggestions of the House. However, some House proposals for benefit increases and eligibility liberalizations were either dropped (e.g., higher benefits for the elderly and disabled with medical expenses and changes in the inflation indexing rules) or substantially modified to reduce their cost (e.g. less liberal increases in the assets eligibility standards). Benefit reduction provisions were significantly modified to narrow their effect to only small portions of the recipient population.

For fiscal year 1985, the original appropriation of $12.3 billion for food stamps (including Puerto Rico's $825 million block grant) did not take into account a 1-percent benefit increase enacted at the end of 1984, and it overestimated an expected drop in food stamp participation. As a result, Congress enacted a $300 million supplemental appropriation for food stamps in the summer of 1985 (Public Law 99–88), bringing total food stamp funding for 1985 to $12.6 billion.

At the end of 1985, the fiscal year 1986 appropriations for food stamps was enacted as part of the omnibus "continuing resolution" (Public Law 99-190). For the first few months of fiscal year 1986, through December 19, 1985, food stamp spending was financed through a series of short-term continuing resolutions. As requested by the administration, the 1986 appropriations level is $12.7 billion (including $825 million for Puerto Rico), a $100 million increase over 1985. For a number of reasons, however, this amount may be insufficient to fund the program fully in 1986, thereby requiring a supplemental appropriation.

In action separate from the 1986 appropriations, Congress agreed to a first concurrent budget resolution for fiscal year 1986 (S. Con. Res. 32, agreed to on August 1, 1985) that assumed no budget reductions for food stamps, and appeared to leave room for up to about $400 million in added spending on nutrition programs (including food stamps) over and above current-law spending levels. The budget reconciliation measure implementing this resolution (H.R. 3128) was pending when Congress adjourned at the end of 1985. Congress, however, has gone ahead and enacted a small spending increase for food stamps in fiscal year 1986 through the approval of the Food Security Act. New spending in 1986 is estimated at about $50 million (with larger costs in later years). In addition, Congress voted to exempt programs under the Food Stamp Act from automatic spending reductions that may be mandated under legislation to reduce the Federal deficit over the next 5 years—the so-called "Gramm-Rudman-Hollings" measure, the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177).

Because the Food Security Act was not enacted until the very end of 1985, certain provisions in the Food Stamp Act scheduled to expire at the end of September 1985 (but earmarked for long-term extension in the House and Senate farm bills) needed to be extended temporarily. Public Laws 99-114, 99-157, and 99-182, provided a series of extensions, through the end of 1985, for: (1) Authority to continue to operate pilot projects granting cash food stamp benefits to the elderly; and (2) authority for Puerto Rico to issue its nutrition assistance in cash. These authorities were both extended for the long term in the Food Security Act.

## D. REGULATION

With one exception, and in expectation of major food stamp legislation, the administration did not pursue significant regulatory changes in 1985. The exception was a decision to seek to limit the degree to which some food stamp recipients who are also participants in the Low-Income Home Energy Assistance Program [LIHEAP] may reduce their countable income due to utility costs. However, in a number of cases this new rule—affecting those whose LIHEAP benefit is paid to their utility provider—has been counteracted by court decisions, and the food stamp provisions of the Food Security Act will require a reworking of the rule to the general benefit of such recipients. As scheduled under law, income eligibility limits were revised upward by about 4 percent in July

1985, and benefit levels and expense deduction limits were revised upward by 2 to 3 percent in October 1985.

## E. PROGNOSIS

There remains irrefutable evidence of a significant problem of poverty-related hunger in this country. In 1985, the Food Stamp Program, designed to counteract this problem, faced one of its most severe challenges since its creation. During the 99th Congress, several major food stamp reform bills were introduced, but in the end, efforts to dismantle or dramatically cut the Food Stamp Program were thwarted. No major additional benefit or eligibility limitations were taken up by Congress. Instead, attention focused on reauthorizing appropriations for the program, work and training initiatives, cost-sharing between the Federal Government and States, State flexibility in administering the program, restoring some of the earlier benefit reductions, and easing access to the program. Thus, while no new massive program spending was committed to the Food Stamp Program, it appears that Congress recognized that cutting food assistance would result in the payment of higher social and health costs.

With the enactment of the Food Security Act of 1985, it is unlikely that there will be significant legislative consideration of food stamps in 1986. A number of factors, however, may necessitate some congressional attention. As noted in the discussion of appropriations, there will likely be a need for a supplemental appropriation for food stamps in 1986, if benefit reductions are to be avoided. And, although food stamps are protected from any automatic spending reductions required by the "Gramm-Rudman-Hollings" measure, the administration may propose, and Congress may choose, to reduce food stamp spending through other legislation intended to avoid the need for triggering automatic reductions.

# Part 3

# HEALTH

For the past several years, the two driving forces of Federal health policy have been rising costs and the perceived need to cut the Federal deficit. This has resulted in major cost containment efforts at the Federal level—efforts that have been mirrored at the State and local levels. In the fury of cost containment activity, concerns about quality and access, once the principal goals underlying most Federal health programs, have taken a back seat.

1985 was again a year in which health policy was largely one and the same with budget policy. The name of the game was to reduce spending, or at the least, hold down increases in program expenditures. The need to cut the overall Federal deficit claimed most of the time of the congressional domestic policy agenda. Few health initiatives were considered apart from the deficit reduction/budget reconciliation process. Medicare, because of its share of the domestic Federal budget, was a major target of budget cuts; the program came under close scrutiny as the administration and Congress looked for places to cut, or to squeeze more value without allowing the customary annual increase in outlays.

There was, however, some good news in 1985 for Medicare. Because of the apparent effectiveness of cost containment policies (such as Medicare's prospective payment system), the insolvency of the hospital insurance (HI) trust fund, previously declared to be imminent, was projected to be at least another ten years away. This eased pressures on Congress to enact new comprehensive program changes, such as prospective payment for physicians or for skilled nursing or home health care.

Emerging with the new optimism for the HI trust fund, however, was a growing concern about the quality of care being delivered to Medicare's beneficiaries. There were clear signs that the new prospective payment incentives were leading to new abuses in the system, diminished access to services and reduced quality of care. The already limited Medicare nursing home and home health benefits were experiencing a tightening vise of budget cuts and increasing demand, as hospitals responded to the incentives of prospective payment and discharged patients earlier and sicker. Whereas cost containment led off the congressional agenda at the beginning of the year, concerns about quality and access were reemerging as priority issues for congressional health policy makers by year's end. Even these concerns, however, would have to be addressed within a framework of a constricting Federal budget.

In 1985, Congress also debated the merits of a variety of changes in the Medicare Program, such as reducing Federal support for graduate medical education, developing an adjustment to the

DRG's for hospitals bearing a disproportionate burden of low-income and Medicare patients, and fine-tuning aspects of the prospective payment methodology such as the area wage index. New initiatives to ensure greater access to long-term care also surfaced, with most of the attention going to those which would encourage private sector development of long-term care insurance.

In addition, consideration was given to new ways to raise revenues for Medicare, such as earmarking tobacco excise tax revenues for the HI trust fund and mandating Medicare coverage of employees of State and local governments. In other areas of health policy, Congress began working on tax reforms that could have a significant impact on new capital investments for nonprofit hospitals, and took a major step in the direction of mandating that certain private, and State and local government, employers, provide continued health insurance coverage to their employees, and the families of their employees, who experience a change in job or family status. Congress also grappled with the challenge of assuring adequate funding for biomedical research in an environment of shrinking Federal dollars.

# Chapter 7

# HEALTH CARE

## OVERVIEW

The health care challenge to Congress in 1985 was to reconcile the need for substantial deficit reduction with our national commitment to provide America's elderly with access to affordable, high quality health care. Almost every health issue affecting the elderly was framed in terms of its effects on the Federal budget, and the congressional health agenda was acted upon almost exclusively through the annual budget reconciliation and appropriations processes. Yet significant progress was made on a number of important issues related to health care access and quality for older Americans. While the major activity revolved around changes to the Medicare Program, there were also important developments in health services research and training, and in responding to the growing problem of the medically uninsured.

## A. MEDICARE

### 1. BACKGROUND

#### (A) HEALTH CARE COSTS

Prior to the mid-1970's, cost of care was not a major issue among health specialists. Instead, expansion of access and the improvement of quality of care were foremost on the Nation's health policy agenda. As costs began to skyrocket, however, concerns began to surface over whether the Nation's health engine was overheated. Between 1960 and 1984, national health expenditures increased from nearly $27 billion or 5.3 percent of GNP to over $387 billion or 10.6 percent of GNP (see chart 7-1). Even given today's slower rate of increase, health care expenditures could reach $660 billion or more than 11 percent of GNP by 1990, and 14 percent of GNP by the year 2000[1] (see chart 7-2).

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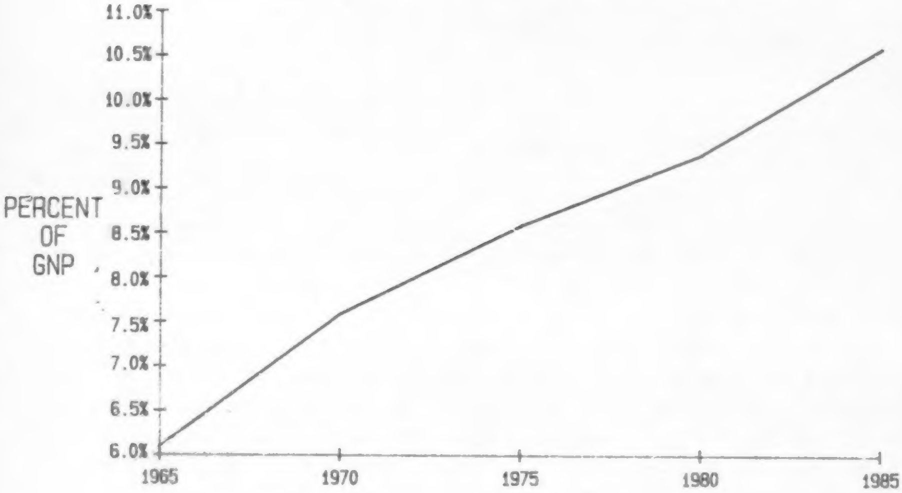
[1] U.S. General Accounting Office. Constraining National Health Care Expenditures: Achieving Quality Care at an Affordable Cost. Sept. 30, 1985. U.S. Govt. Printing Off., Gaithersburg, Maryland. pp i,4.

CHART 7-1

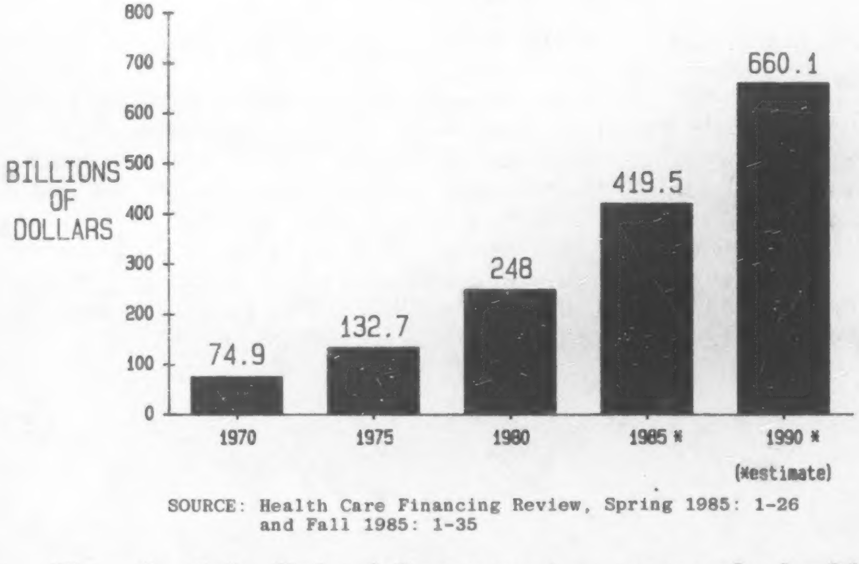
NATIONAL HEALTH EXPENDITURES
AS A PERCENT OF GROSS NATIONAL PRODUCT



SOURCE: Health Care Financing Review, Winter, 1984: 1-29 and Fall 1985: 1-35

CHART 7-2

NATIONAL HEALTH SPENDING
1970 - 1990



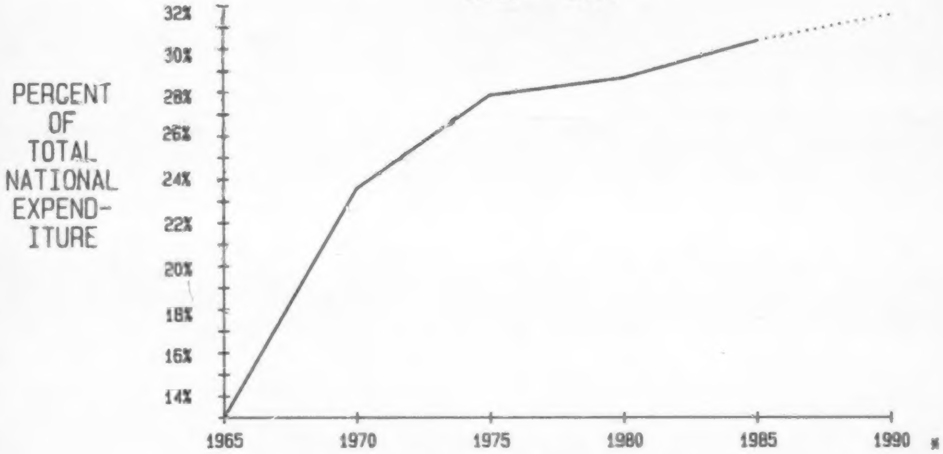
SOURCE: Health Care Financing Review, Spring 1985: 1-26 and Fall 1985: 1-35

The role of the Federal Government as a payor for health services has grown with the overall increases in health care costs. In

1965, the Federal Government paid just over 13 percent ($5.5 billion) of the Nation's health bill compared to 29 percent ($111.9 billion) of total costs in 1984. Projections of future health bills facing the Federal Government suggest a continued increase in the Federal cost burden exceeding $200 billion by 1990[2] (see chart 7-3).

CHART 7-3

FEDERAL SPENDING ON THE NATION'S HEALTH
1965 - 1990



SOURCE: Health Care Financing Review, Spring 1985: 1-26 and Fall 1985: 1-35

(*projection)

During this period of expansion, the structure and delivery of health care were plagued by perverse incentives, resulting in the overutilization of services, inefficiency and waste. The cost-based system of reimbursement, which characterized most of health care delivery, was identified as the principal culprit. To make the system more efficient, policy experts reasoned, reimbursement should be made prospectively, on the basis of predictable payment rates that reflected the resource need of each patient.

Led by the Federal Government, which was incurring major expenditure increases each year to pay for Medicare, Medicaid, and other health programs, third-party payers began to question whether large scale reform of health care was needed. In 1983, Congress and the administration worked together to achieve the creation of the prospective payment system (PPS) for Medicare reimbursement of hospitals. This has been the most dramatic change in the Medicare Program since it was enacted.

*Prospective payment system.*—The Medicare prospective payment system pays hospitals fixed amounts that correspond to the average costs for a specific diagnosis. PPS uses a set of 471 diagnosis related groups (DRG's) to categorize patients for reimbursement. The amount a hospital receives from Medicare no longer depends on the amount or type of services delivered to the patient; therefore, there are no longer incentives to overuse services. If a hospital can treat a patient for less than the DRG amount, it can keep the savings. If the treatment for the patient costs more, the hospital must absorb the loss. Hospitals are not allowed to charge beneficiaries any difference between hospital costs and the Medicare DRG payment amount. Without changes in current law, DRG payment rates will be adjusted so that all rates will be determined on a national basis by 1987.

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[2] Arnett, Ross H., III, et al. Health Spending Trends in the 1980s: Adjusting to Financial Incentives. Health Care Financing Review. vol. 6 no. 3, Spring 1985.

In the wake of the 1983 Medicare PPS reform, States have moved quickly to adopt prospective payment methodologies for their Medicaid programs. Private payers, too, are advancing a hybrid of reimbursement reforms, ranging from prospective rate setting to innovative capitation schemes. The health care arena is in fact changing so rapidly on so many fronts—not just cost containment—that any broad characterization of it today is likely to be outmoded by tomorrow. Nevertheless, it seems a fair generalization to say that the overriding factor influencing the nature of our Nation's health care system is that of cost containment.

Over the short term, at least, these efforts seem to be working. In 1984, the most recent year for which data are available, the rate of growth in total health care expenditures was 9.1 percent, rising to $387.4 billion from $355.1 billion in 1983. This was the lowest rate of annual growth over the past 20 years, dropping below the 10 percent rate of growth achieved during the Economic Stabilization Program in 1973 when some price increases were artificially constrained.

The current low rate of growth is attributable to a number of factors, and not cost containment measures alone. According to the Department of Health and Human Services (DHHS), the slowdown has also resulted from a low rate of inflation in the economy as a whole, and changing patterns of demand for services, in particular a decline in the use of hospital inpatient services (American Hospital Association survey data show that community hospital admissions fell by 3.7 percent and inpatient days by 8.6 percent.[3]

Our Nation's health care system may be paying a large price for its new lean and mean look. The overriding pressures to reduce costs and make health care delivery more efficient may be succeeding at the expense of reduced access to and diminished quality of health care. We may in fact be faced with a most difficult tradeoff. Given an economy struggling with high budget deficits, the goals of "unlimited access" and "highest possible quality" are being questioned. This presents us with the dilemma of deciding how, in a period of limited national resources, do we maintain access to the health care system while preserving its quality.

National expenditures for hospital care and physicians' services exceed expenditures for all other health services combined. In 1983 spending for these two services constituted 68 percent of the total costs for personal health care. Hospital care costs are the single largest component of the Nation's health care bill. In 1984, 46 percent ($157.9 billion) of the $341.8 billion spent on personal health was paid to hospitals. During this same year physicians were paid

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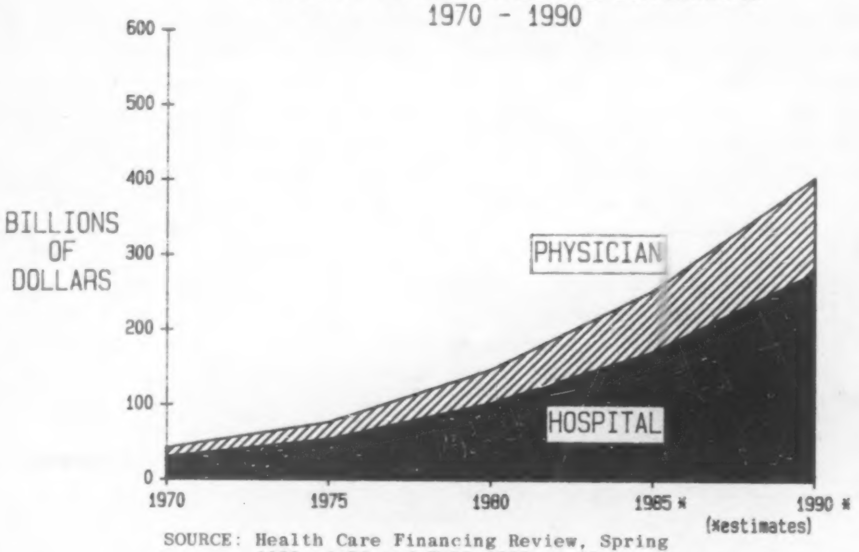
[3] U.S. General Accounting Office. Constraining National Health Care Expenditures: Achieving Quality Care at an Affordable Cost. Sept 30, 1985. U.S. Govt. Print. Off., Gaithersburg, Maryland. p. 9.

$75 billion, the second largest portion of health care spending (see chart 7-4).

CHART 7-4

NATION'S HEALTH CARE BILL
PAYMENTS TO HOSPITALS AND PHYSICIANS
1970 - 1990



SOURCE: Health Care Financing Review, Spring 1985: 1-26 and Fall 1985: 1-35

### (B) HEALTH CARE UTILIZATION

The health status of the elderly is shaped by a full course of life experiences and health habits. While most older people are basically healthy and report themselves in good to excellent health, many tend not to report specific health problems and mistakenly think they are caused by old age rather than disease. Yet age does affect a person's health, mainly by influencing the way the body reacts to diseases and drugs.

Americans of all ages are healthier today than they were 10 to 20 years ago. However, individual assessment of a person's own health is often the most important measure of health status. Women over age 65 tend to report better health than men do in the same age group. Self-assessed health status is also strongly related to an individual's use of health services.

Chronic diseases are a major threat to the independence of older persons. Arthritis, hypertension, heart conditions, and hearing disorders are leading chronic conditions among the non institutionalized elderly. Most older persons that require hospitalization do so for an acute episode of a chronic illness. Visits to the doctor are also most often for treatment of chronic conditions.

The dimensions of the current health service consumption of the aged only hint at future needs. The consumption of health services by the aged is growing because of absolute increases in the total aged population, greater numbers of individuals in the eldest subgroup, and an increased number of services provided per person. Higher expectations for good health, the availability of third party financing and increased access to certain medical advances (i.e., renal dialysis, radiation therapy) are also prominent among the factors contributing to greater use of health services by the elderly.

### *(1) Hospital Utilization*

Short-stay hospital visits by the elderly increased more than 50 percent between 1965 and 1983. Since then, admissions for elderly patients have decreased. In 1983, a survey of non-Federal short stay hospitals revealed that 11.3 million elderly patients were discharged from hospitals; this figure represented 29 percent of all patient stays (table 1). The population 75 and over accounted for 15.1 percent of short stay hospital days. Although the average length of stay has been declining, from 11.1 days for an elderly patient in 1977 to 9.7 days in 1983, older persons tend to remain in the hospital longer than the general population. The hospital discharge rate for those 85 and over was 84 percent higher than that for the 65 to 74 year age group. The average hospital stay for persons age 65 to 74 was about 9 days in 1983 as compared with 9.7 days for the 85 and over group.

TABLE 1.—UTILIZATION OF SHORT-STAY HOSPITALS FOR SELECTED AGE GROUPS, 1983

| Age group | Discharged patients | | | Days of care | | | |
|---|---|---|---|---|---|---|---|
| | Number in thousands | Percent distribution | Rate per 1,000 | Number in thousands | Percent distribution | Rate per 1,000 | Average length of stay in days |
| All ages | 38,783 | 100.00 | 167.0 | 268,337 | 100.0 | 1,155.2 | 6.9 |
| 45 to 64 | 8,558 | 22.1 | 192.2 | 65,029 | 24.2 | 1,460.6 | 7.6 |
| 65 to 74 | 5,468 | 14.1 | 334.2 | 50,222 | 18.7 | 3,069.5 | 9.2 |
| 75 to 84 | 4,295 | 11.1 | 504.2 | 42,416 | 15.8 | 4,979.6 | 9.9 |
| 85+ | 1,539 | 4.0 | 614.8 | 17,016 | 6.3 | 6,798.4 | 11.1 |
| 65+ | 11,302 | 29.2 | 412.7 | 109,655 | 40.9 | 4,004.3 | 9.7 |

Source: 1983 Hospital Discharge Survey, National Center For Health Statistics.

### *(2) Use of Physicians' Services*

Utilization of physician services increases with age. Approximately four out of five elderly living in the community had at least one contact with a physician in 1983.[4] More than 16 percent of total physician visits during 1983 were made by persons 65 and over. On the average, elderly people are more likely than younger ones to make frequent visits to a physician. Persons 65 and older visit a physician six times for every five times by the general population. Since the enactment of Medicare, the average number of physician contacts and the percentage of persons 65 and over reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.[5]

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[4] Kovar, Mary Grace, Elderly People and Their Medical Characteristics. National Center for Health Statistics, Washington, D.C., p. 33.

[5] U.S. Senate Special Committee on Aging, America in Transition: An Aging Society. Washington, D.C., U.S. Govt. Print. Off., 1984–85 edition, p. 77.

Approximately three-quarters of visits by the elderly are made to a doctor's office. The remaining visits are divided among hospital emergency rooms, out-patient departments, home and telephone consultations. The higher use of physicians' services by the elderly is associated with their probability of being in poor health. The majority of those who had not seen a physician in 1980 considered themselves in good health.

The aging of the population will create a greater demand for medical care. The need for physician visits will increase by 18 percent (over 30 million visits) by the year 2000, and by 30 percent (over 50 million visits) by 2020. These figures are based on 1980 physician visit rates (153 million visits) and the U.S. Census Bureau population projections.[6]

Because the number of chronic conditions an individual experiences is likely to be greater with advanced age, the health care needs of the elderly are broad in scope and require the participation of a number of health care professionals who are educated in geriatrics and gerontology. In addition to physicians, nurses have substantial responsibilities for providing services to the elderly in a wide range of settings such as hospitals, long-term care settings, ambulatory care programs and day care programs. Dentists, social workers, and allied health care professionals also can actively contribute to the care of the elderly when they are educated about the needs of their older patients.

Available data, however, indicate that only a small fraction of health care professional schools have required curricula in geriatrics and gerontology.[7] In 1984, only 5 to 25 percent of the cadre of competent teachers and researchers who were required to address this need were available.[8]

### *(3) Use of Disease Prevention Services*

Utilization of disease prevention services by the elderly varies by type of service. The majority of the elderly do not seek health services if they perceive themselves to be in good health. The elderly who report that they have not seen a physician within a year, for example, also report that they have no need for physician care.

Elderly persons visit dentists less often than the younger population. Only 35 percent of the 65 and older population visited a dentist in 1981 as compared with 52 percent of the population 45 to 64.[9] At present, older persons do not receive sufficient preventive or therapeutic dental care. It is estimated that almost one-third of the population is likely to lose some or all of their teeth between the ages of 50 and 70; the major cause of loss of teeth is periodontal disease. Studies have shown that improvement in oral hygiene and plaque control is effective in preventing dental and periodontal disease in adults.

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[6] Ibid., p. 78.

[7] U.S. Dept. of Health and Human Services, National Institute on Aging. Report on Education and Training in Geriatrics and Gerontology. Washington, D.C. U.S. Govt. Print. Off., February, 1984, p. 5.

[8] Ibid., p. 51.

[9] U.S. Senate Special Committee on Aging. America in Transition: An Aging Society. Washington. U.S. Govt. Print. Off., 1984-85 ed., p. 78.

Examples of functional impairments that can be corrected or compensated for in the elderly are visual and hearing problems. Yet, these deficits are among the best examples of conditions that older persons often do not seek to remedy. High cost and a lack of Medicare reimbursement discourages many older persons from buying eyeglasses and hearing aids.

Many of the chronic conditions of the elderly are strongly associated with personal health habits. In general, the evidence linking changes in health habits by older persons to reduced risk of disease is fragmentary. A number of behaviors such as diet, exercise, and stress reduction are worthy of the attention of health care professionals because intervention in these areas will have visible positive effects. Appropriate intervention associated with these behaviors will foster a sense of well-being, enhance the self-concept of the elderly, and promote social interaction. The most dramatic example of a behavior change that produces positive effects on health is cigarette smoking, which is a major risk factor in cardiovascular diseases and selected cancers. When a person of any age stops smoking, the benefits to the heart and the circulatory system begin right away. The risk of heart attack and stroke drops and circulation to the hands and feet improves. Nonsmokers also have a lower risk of contracting influenza, pneumonia, and colds. Influenza and pneumonia can sometimes be life-threatening diseases for older persons.

### *(4) Health Care Expenditures of the Elderly*

Persons 65 and over, 12 percent of the population in 1984, account for a third of the Nation's total personal health care expenditures.[10] These expenditures represent total health care investment from all sources exclusive of research.[11] Per capita spending for health care in 1984 represented a 13-percent annual growth rate from 1977. Total personal health care expenditures of the elderly were expected to reach $120 billion in 1984 (tables 2–5).

TABLE 2.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

| Year and source of funds | Type of service | | | | |
|---|---|---|---|---|---|
| | Total care | Hospital | Physician | Nursing home | Other care |
| 1984: | | | | | |
| Total per capita | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Private | 32.8 | 11.4 | 39.7 | 51.9 | 65.3 |
| Consumer | 32.4 | 11.0 | 39.6 | 51.2 | 64.8 |
| Out-of-pocket | 25.2 | 3.1 | 26.1 | 50.1 | 59.9 |
| Insurance | 7.2 | 7.9 | 13.5 | 1.1 | 4.9 |
| Other private | .4 | 0.4 | .0 | .7 | .5 |
| Government | 67.2 | 88.6 | 60.3 | 48.1 | 34.7 |
| Medicare | 48.8 | 74.8 | 57.8 | 2.1 | 19.9 |
| Medicaid | 12.8 | 4.8 | 1.9 | 1.5 | 11.4 |
| Other government | 5.6 | 9.1 | .7 | 4.4 | 3.4 |

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[10] Ibid., p. 79.
[11] Ibid., p. 79.

## TABLE 3.—DISTRIBUTION OF PER CAPITA PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY TYPE OF SERVICE AND SOURCE OF FUNDS: UNITED STATES, 1984

| Year and source of funds | Total per capita | Type of service | | | | |
|---|---|---|---|---|---|---|
| | | Total care | Hospital | Physician | Nursing home | Other care |
| 1984: | | | | | | |
| Total per capita | $4,202 | 100.0 | 45.2 | 20.7 | 20.9 | 13.2 |
| Private | 1,379 | 100.0 | 15.7 | 25.0 | 33.1 | 26.2 |
| Consumer | 1,363 | 100.0 | 15.3 | 25.3 | 33.1 | 26.3 |
| Out-of-pocket | 1,059 | 100.0 | 5.6 | 21.4 | 41.6 | 31.3 |
| Insurance | 304 | 100.0 | 49.2 | 38.6 | 3.3 | 8.9 |
| Other private | 16 | 100.0 | 42.1 | 1.9 | 39.1 | 17.0 |
| Government | 2,823 | 100.0 | 59.7 | 18.6 | 15.0 | 6.8 |
| Medicare | 2,051 | 100.0 | 69.2 | 24.5 | .9 | 5.4 |
| Medicaid | 536 | 100.0 | 17.0 | 3.1 | 68.1 | 11.8 |
| Other government | 236 | 100.0 | 73.2 | 2.4 | 16.5 | 7.9 |

## TABLE 4.—PERSONAL HEALTH CARE EXPENDITURES IN MILLIONS FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

| Year and source of funds | Type of service | | | | |
|---|---|---|---|---|---|
| | Total care | Hospital | Physician | Nursing home | Other care |
| 1984: | | | | | |
| Total | $119,872 | $54,200 | $24,770 | $25,105 | $15,798 |
| Private | 39,341 | 6,160 | 9,827 | 13,038 | 10,316 |
| Consumer | 38,875 | 5,964 | 9,818 | 12,856 | 10,237 |
| Out-of-pocket | 30,198 | 1,694 | 6,468 | 12,569 | 9,467 |
| Insurance | 8,677 | 4,270 | 3,350 | 287 | 770 |
| Other private | 466 | 196 | 9 | 182 | 79 |
| Government | 80,531 | 48,040 | 14,943 | 12,067 | 5,482 |
| Medicare | 58,519 | 40,524 | 14,314 | 539 | 3,142 |
| Medicaid | 15,288 | 2,595 | 467 | 10,418 | 1,808 |
| Other government | 6,724 | 4,920 | 162 | 1,110 | 532 |
| Exhibit: Population (in millions) | 28.5 | | | | |

## TABLE 5.—PERSONAL HEALTH CARE EXPENDITURES IN MILLIONS FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

| Year and source of funds | Type of service | | | | |
|---|---|---|---|---|---|
| | Total care | Hospital | Physician | Nursing home | Other care |
| 1984: | | | | | |
| Total | $4,202 | $1,900 | $868 | $880 | $554 |
| Private | 1,379 | 216 | 344 | 457 | 362 |
| Consumer | 1,363 | 209 | 344 | 451 | 359 |
| Out-of-pocket | 1,059 | 59 | 227 | 441 | 332 |
| Insurance | 304 | 150 | 117 | 10 | 27 |
| Other private | 16 | 7 | 1 | 6 | 3 |
| Government | 2,823 | 1,684 | 524 | 423 | 192 |
| Medicare | 2,051 | 1,420 | 502 | 19 | 110 |
| Medicaid | 536 | 91 | 16 | 365 | 63 |
| Other government | 236 | 172 | 6 | 39 | 19 |

Source: Waldo, Daniel R., Lazenby, Helen C.; Demographic Characteristics and Health Care Use and Expenditures by the Aged in United States: 1977–84; "Health Care Financial Review," vol. 6, No. 1, fall 1984.

### *(5) Health Care Expenditures by Source*

#### *(a) Hospital*

Hospital care for the aged is projected to cost $54 billion in 1984; this is an amount equal to $1,900 per capita. Medicare reimbursement will account for three-quarters of that amount; other sources of public funds will pay about 15 percent of the bill. Private health insurance will cover 8 percent of the costs; the remaining 3 percent will be paid out-of-pocket.[12]

#### *(b) Physicians' services*

Spending for physician services to the elderly grew an average of 18 percent per year from 1977 to 1984, reaching a projected level of $24.8 billion for 1984.[13] The growth in patient days spent in the hospital by the elderly (3 percent increase per year during the period 1977–83) largely accounts for the increase in physician services and costs.[14]

## (C) MEDICARE PROGRAM DESCRIPTION

Medicare was enacted in 1965 to insure older Americans for the cost of acute health care. Over the past two decades, Medicare has provided millions of older Americans with access to quality hospital care and physicians services at affordable costs. In 1985, Medicare insured nearly 27 million aged and 3 million disabled individuals. At a 1985 estimated cost of $71 billion, Medicare is the second most costly Federal domestic program, exceeded only by the Social Security Program [see chart 7–5].

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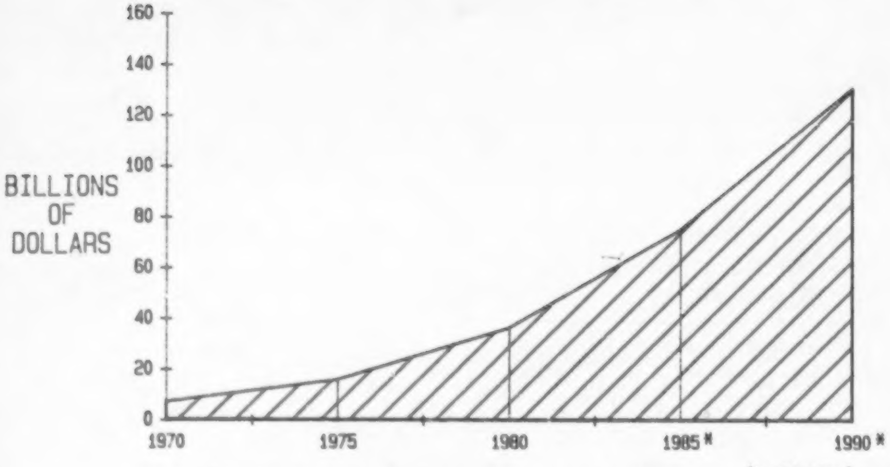
[12] Waldo, Daniel R. and Helen C. Lazenby. Demographic Characteristics and Health Care Expenditures by the Aged in the United States: 1977–84. Health Care Financing Review. vol. 6, no. 1, Fall, 1984, p. 12.

[13] Ibid., p. 13.

[14] Ibid., p. 13.

CHART 7-5

MEDICARE PROGRAM COSTS
1970 - 1990



SOURCE: Health Care Financing Review, Spring 1985: 1-26 and Fall 1985: 1-35

As insurance for short-term acute illness, Medicare covers most of the costs of hospitalization and a substantial share of the costs for physician services. Medicare does not cover the hospital costs of extended acute illnesses, however, and does not protect beneficiaries against potentially large co-payments or charges above the Medicare payment rate for physician services. These shortcomings in Medicare's coverage of the costs of acute illness have led two-thirds of older Americans to purchase supplemental private coverage, often referred to as medigap coverage.

Medicare (authorized under title XVIII of the Social Security Act) is a nationwide program that provides health insurance protection to most individuals age 65 and over, to persons who have been entitled to Social Security or railroad retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed of two parts—the Hospital Insurance Program (Part A), and the Supplementary Medical Insurance Program (Part B).

### *(1) Hospital Insurance (Part A)*

Part A is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. During calendar year 1985, each worker and employer paid a tax of 1.35 percent on the first $39,600 of covered employment earnings. The self-employed paid both the employer and employee shares.

In 1984, the last year for which there are complete data, hospital insurance (HI) payroll taxes amounted to $42.3 billion, accounting for 90.5 percent of all HI income. About 2.1 percent of all income resulted from a lump sum transfer from the general fund of the Treasury for military service wage credits, and reimbursements for certain uninsured persons. Interest payments to the HI fund equalled 6.5 percent of all HI income for 1984. The remaining 0.8 percent was contributed through premiums paid by voluntary enrollees and taxes collected from railroad workers. Of the $43.9 billion in HI disbursements, $43.3 billion was for benefit payments while the remaining $0.6 billion (1.4 percent) was spent for administrative expenses.[15]

During each benefit period (defined as beginning when an insured person enters a hospital and ending when he or she has not been in a hospital or skilled nursing facility for 60 days), Part A pays for:

1. Ninety days of inpatient hospital care, subject to a deductible ($400 in calendar year 1985; $492 in calendar year 1986); and a daily copayment ($100 in 1985; $123 in 1986) that is required for the 61st through 90th day. An additional lifetime reserve of 60 days, subject to a daily copayment ($200 in 1985; $246 in 1986) may be drawn upon when an individual exceeds 90 days in a benefit period. Both the deductible and copayment amounts are adjusted annually;
2. One hundred days of post-hospital skilled nursing facility (SNF) care, which are subject to a daily copayment ($50 in 1985; $61.50 in 1986) after the first 20 days;
3. Home health care is provided on a part-time or intermittent basis. There is no specified limit on the number of visits and no copayment is required;
4. Hospice services for the terminally ill are also covered. A beneficiary may elect to receive services for two 90-day periods and one subsequent 30-day period during his or her lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits. This election may be revoked.

Hospital reimbursement under Medicare is now in transition from the original retrospective cost-based reimbursement method of payment to a prospective system of payment rates based on diagnosis related groups (DRG's). Under PPS, hospitals are paid a set price for each case, as classified into 471 DRG's. The phase-in of prospective payment by DRG rates began in October 1983, and, in the absence of congressional action, will be completed by October 1, 1987.

### *(2) Supplementary Medical Insurance (Part B)*

Part B of Medicare, supplementary medical insurance (SMI), is a voluntary program financed jointly through monthly premium charges ($15.50 in 1985 and 1986) on enrollees and Federal general revenues. Premiums cover 25 percent of program costs; 75 percent are funded from general revenues. Part B (with certain exceptions) pays 80 percent of reasonable charges for the following covered services after the insured meets a $75 deductible: physician and other professional services, diagnostic tests, medical devices, outpatient hospital services, and laboratory services.

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[15] U.S. Department of Health and Human Services, Health Care Financing Administration. Summary of 1985 Annual Reports of the Medicare Board of Trustees. Washington, April 1, 1985, p. 5.

In 1984, the last year for which there are data, 29.4 million people were covered under SMI. General revenue contributions equalled $17.1 billion, accounting for 73.6 percent of all income. Another 22.3 percent of all income resulted from premiums paid by participants, with interest payments to the SMI fund accounting for the remaining 4.1 percent. Of the $20.6 billion in SMI disbursements, $19.7 billion was for benefit payments while the remaining $0.9 billion (4.3 percent) was for administrative costs.[16]

*Physician reimbursement.*—Medicare pays physicians the "reasonable charge rate" for their service, less the deductible and the copayment. The reasonable charge for a service is the lowest of three dollar amounts: (1) The physician's actual bill for the services; (2) the amount which the physician usually charges for the service; or (3) the usual charge made for this service by all physicians in the same locality. Under the Deficit Reduction Act of 1984 (DEFRA, Public Law 98-369), physican fees were frozen under Medicare for the 15-month period, July 1, 1984 through September 30, 1985. This freeze was extended through November 14, 1985 (Public Law 99-107), extended again through December 14, 1985 (Public Law 99-155), and then extended yet another time (Public Law 99-201) through March 14, 1986. Therefore, the annual updating of customary and prevailing charge screens, otherwise slated for July 1, 1984, did not occur.

DEFRA established the concept of the participating physician. A participating physician is one who voluntarily enters into an agreement with the Secretary to accept asssignment for all services provided to all Medicare patients for a future 12-month period. The first period began October 1, 1984. The second began October 1, 1985. After these dates, only new physicians in an area or newly licensed physicians could enter into a participation agreement until the next designated period.

Participating physicians were subject to the first 15-month freeze. They were, however, permitted to increase their billed charges during the freeze period. While increases in billed charges will not raise Medicare payments during the freeze period, these charges will be reflected in the calculation of future customary fee screen updates. The law included additional incentives for physicians who agree to become participating physicians. These include the publication of directories identifying participating physicians and the maintenance by Medicare carriers of toll free lines to provide beneficiaries with names of participating physicians. In February, 1985 DHHS reported that 29.8 percent of physicians were participating.

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[16] Ibid., p. 19.

Since the enactment of DEFRA, nonparticipating physicians (i.e., those who have not signed a voluntary participating agreement) could continue to accept assignment on a case-by-case basis. They could not, however, increase their billed charges during the 15-month freeze period over the amounts charged for the same services during the April 1 through June 1, 1984, period. The law required the Secretary to monitor charges of nonparticipating physicians to determine compliance with the fee freeze. Nonparticipating physicians who did not comply with the freeze were subject to civil monetary penalties or assessments, exclusions for up to 5 years from the Medicare Program, or both.

### *(3) Peer Review Organizations*

Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), replaced the existing Professional Standards Review Organizations (PSRO) program with a utilization and quality control peer review program. The Secretary of DHHS was required to enter into performance-based contracts with physician-sponsored or physician-access organizations known as peer review organizations (PRO's) by November 15, 1984. Hospitals receiving payment under the new prospective payment system are required to enter an agreement with a PRO under which the PRO will review the validity of diagnostic information provided by the hospitals; the completeness, adequacy and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of care provided to patients designated by hospitals as outliers (i.e., cases which are extraordinarily costly to treat based on cost and length of stay criteria).

### *(4) The HMO Benefit*

During 1982 and 1983, DHHS awarded demonstration contracts to 26 organizations to develop HMO's for Medicare beneficiaries in 21 cities across the country. The actual implementation of the statutory authority to contract was delayed for several years within the DHHS because of the administration's concerns over short-term costs attached to the provision and technical difficulties in setting prospective rates. But final regulations implementing this authority were published on January 10, 1985, and in February 1985 the Department initiated a nationwide program providing for the expanded use of HMO's by Medicare.

The Medicare-HMO benefit is assuming an increasingly significant role in providing health care to older persons. Between June 1984 and June 1985, the number of HMO's serving Medicare beneficiaries as part of their larger total enrollment rose from 105 to 180, an increase of 71 percent. The number of Medicare beneficiaries enrolled in these HMO's rose from 671,186 to 923,848, an increase of 38 percent. Medicare beneficiaries now comprise 5 percent of all HMO enrollees.

Two kinds of organizations are now eligible to contract with Medicare: those that are federally qualified HMO's under the 1973 HMO Act, and "competitive medical plans" as defined in TEFRA. These plans have many of the characteristics of HMO's but are allowed to experience rate their premiums and to impose deductibles on beneficiaries. This category of plans was created to broaden participation and to stimulate competition in the medical marketplace.

Each month, Medicare pays these participating organizations a premium for every beneficiary-member. This payment—the average adjusted per capita cost—is equal to 95 percent of what Medicare estimates it would have paid traditional providers (hospitals and fee-for-service physicians) in the same community. HMO's are also permitted to charge beneficiaries a monthly premium which is equal to the value of traditional Medicare deductibles and copayments.

### (D) SUPPLEMENTAL HEALTH COVERAGE

From its enactment, Medicare was never intended to cover its beneficiaries' total health care expenditures; several types of services are not covered at all, others are covered to some extent but require the beneficiary to pay deductibles, copayments, and coinsurance. Medicare has consistently covered approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Other health care expenditures remain to be covered by Medicaid, private supplemental health insurance, and other sources.

According to HCFA's National Medical Care Utilization and Expenditure Survey of 1980, 67 percent of the aged Medicare population has private insurance in addition to Medicare. Of the $41.7 billion in total medical expenses incurred by noninstitutionalized aged Medicare beneficiaries in 1980, Medicare paid 56 percent, patients and their families paid 18 percent, Medicaid paid 7 percent, and private insurance plans paid 15 percent. The likelihood of having private insurance in addition to Medicare increased among those with more education, and those with higher family incomes. Among the Medicare beneficiaries who had private insurance coverage, 82 percent had one private insurance plan, 17 percent had two or more, and 3 percent had three or more. Approximately 54 percent of the aged Medicare beneficiaries with private insurance had Blue Cross/Blue Shield plans, 45 percent had commercial insurance, and 6 percent were enrolled in HMO's or other prepaid health plans.

Private insurance purchased by the elderly generally concentrates its coverage on services which are covered by Medicare. For instance, in 1977, 97.6 percent of all privately insured elderly persons with Medicare coverage had supplemental coverage for hospital inpatient services, and 60 percent had coverage for ambulatory physicians' services, outpatient diagnostic services, and care in skilled nursing facilities. On the other hand, relatively few Medicare beneficiaries had private insurance which covered services excluded from Medicare coverage: Only 40.6 percent had coverage for medicines prescribed outside the hospital, and only 4.1 percent had any dental coverage.

Group insurance often provides major medical coverage, requiring a substantial deductible but offering comprehensive coverage of remaining expenses. By contrast, about 75 percent of the elderly with individually purchased insurance held no major medical benefits. Group policy benefits were also superior to nongroup insurance in their coverage of fees exceeding the Medicare allowable charge. Group health insurance offers premium advantages, as well as coverage advantages, to the Medicare population. This is possible largely because employers make group insurance affordable.

Medicare beneficiaries insured under group policies had a mean annual premium of $547, compared to only $201 for persons with nongroup insurance, but employers paid 58.1 percent of this expense on average. Thus, the out-of-pocket cost of private insurance for persons with group and nongroup insurance was virtually the same, $196 versus $197. Yet persons with group insurance were more likely to have coverage for services not covered, or partially covered, by Medicare than were persons with nongroup insurance. The lower cost of administering and marketing group insurance also helps keep premiums low in relation to expected benefits: In 1977, benefits paid by group health insurance plans sold to the general population averaged 90 percent of group premiums, whereas nongroup insurance plans paid out only 50 percent of their premiums in benefits. Thus, through lower administrative costs and high employer contributions, persons with group insurance typically obtained a higher range of benefits than persons with nongroup insurance.

## 2. Issues

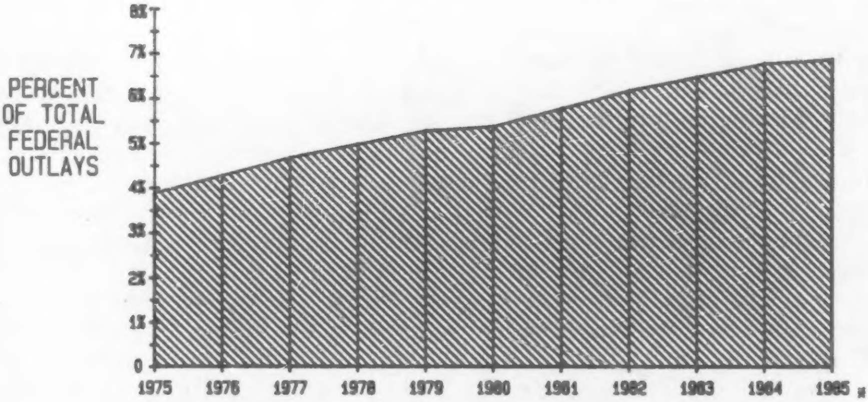
### (A) MEDICARE SOLVENCY AND COST CONTAINMENT

Total costs for Medicare have steadily increased since the program was enacted. Outlays for both benefits and administrative expenses increased from $4.6 billion in 1967 (the first full year of the program) to $65 billion in 1984, comprising 47 percent of total public outlays for health care. By 1990, Medicare outlays are expected to reach over $100 billion.

The rise in Medicare costs has been a concern on two levels. First, Medicare has been consuming an increasing share of the Federal pie. In 1985, expenditures on Medicare represented about 7 percent of the total Federal budget. This compares with a little over 4 percent in fiscal year 1976. [See chart 7–6.]

CHART 7-6

MEDICARE OUTLAYS
PERCENTAGE OF TOTAL FEDERAL OUTLAYS



SOURCE: Budget of the United States Government Fiscal Year 1986. Office of Management and Budget

(*estimate)

With deficits expected to be over $200 billion in fiscal year 1986, there are strong pressures to curb the growth in Medicare outlays. As the second most expensive domestic program, it provides a major target for deficit reduction efforts. While part A is largely funded out of the hospital insurance trust fund and should be, in the view of many in Congress, taken out of the unified budget, part B is largely funded out of general revenues. It is thus a prime target for annual spending cuts. By law, only 25 percent of the Supplemental Medical Insurance (SMI) program is financed by premiums paid by beneficiaries. The bulk of SMI goes to pay for physician services. Thus as physician payments increase, so too will pressures on the general Treasury to finance part B—a fact that has underscored the need to bring effective cost containment to physician and other part B expenditures.

A second driving force for Medicare cost containment is the need to assure solvency of the hospital insurance trust fund. The introduction of PPS, along with other factors slowing inflation in the medical marketplace, has given new life to the trust fund. In 1984, the Medicare trustees' were estimating that the HI fund would go bankrupt by 1989 under pessimistic economic assumptions and 1992 under intermediate economic assumptions. In the 1985 report, the trustees revised their projections, estimating that the HI trust fund would remain solvent until 1998 under intermediate economic assumptions, and 1992 under pessimistic ones. The reasons for the trustees' more optimistic projection were that (1) DHHS had indicated that it would set the PPS hospital payment rates at the same level as for fiscal year 1985, and (2) even in the absence of such a freeze, the payment rates could go up no higher than the hospital input price index plus one-quarter percent, a legislatively mandated reduction of three-quarter percent.

Nevertheless, there remains a legitimate concern that the present financing schedule for the HI trust fund is inadequate to ensure its long-term health. According to the trustees, "in order to bring the HI trust fund into close actuarial balance for the first 25 year projection period under alternative II-B assumptions (intermediate economic assumptions), either disbursements of the program will have to be reduced by 19 percent or income will have to be increased by 24 percent." [17] Moreover, because of changing demographics, there will be increasingly fewer workers to support each Medicare beneficiary as we move into the next century. Today, there are four covered workers supporting each Medicare HI enrollee. By the middle of the next century, there will be only slightly more than two covered workers supporting each enrollee. Thus, there is a pressing need to build reserves now to ensure the same level of benefits to the next generations of elderly.

*Impact of past cost-containment efforts.*—Some progress has been made toward lowering future costs and ensuring the solvency of Medicare. According to HCFA's 1984 report on the impact of PPS on Medicare, PPS "appears to have slowed the increase in Medicare inpatient hospital payments. Although the increase is still above the general rate of inflation, it appears to represent a downturn in the rapid growth of inpatient hospital payments that was seen as a major threat to the solvency of the Medicare trust funds. The estimated real rate of growth (i.e., the rate of growth after adjustment for the overall rate of inflation) in Medicare inpatient hospital payments in fiscal year 1984 was 3.8 percent, compared to the annual 10 percent real rate of increase between fiscal year 1973 and fiscal year 1982." [18]

HCFA also indicated that the rate of growth of Medicare outpatient hospital payments was lower in 1984 than in previous years, increasing about 7.3 percent. Physician payments also grew at a slower rate: 6.2 percent as compared to an annual 8.9 percent real rate of increase between fiscal year 1973 and fiscal year 1982. HCFA stated that it did not know the degree to which this drop was attributable to the freeze on physician payments. [19]

*Further reforms needed.*—In working out the means to prevent the future insolvency of the trust fund, Congress may have to make further systemwide changes to the Medicare Program. There is, however, no consensus at this time about how reform is to be achieved. Some, for example, advocate tapping new sources of revenue for the trust fund such as additional premiums, an income tax surcharge to be paid by Medicare beneficiaries, dedicated additional excise taxes on tobacco and alcohol, and funds from general tax revenues. Others propose to transform the basic mode of health care delivery to a delivery system dominated by organizations that manage the provision of health care, such as health maintenance organizations and health insuring organizations. Still others suggest that Medicare costs can be contained by cutting back coverage, by requiring a means test for eligibility, or by altering payment incentives to make providers more efficient.

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[17] Ibid., p. 14.

[18] U.S. Department of Health and Human Services, Report to Congress: The impact of the Medicare Hospital Prospective Payment System, 1984. Washington, D.C. p. xvii.

[19] Ibid., p. xvii.

*Cost-containment and cost-shifting.*—While there has always been a certain degree of cost-sharing and cost-shifting in the Medicare Program, the problem has worsened with Federal cost-containment efforts. Medicare was not designed to provide beneficiaries with comprehensive health benefits; preventive health care, long-term care and prescription drugs are just some of the areas not covered that have to be paid for by the beneficiary either through supplemental insurance coverage or out-of-pocket. In addition, "shortfalls in Medicare . . . reimbursement of doctors and hospitals have led health care providers to shift unreimbursed costs of serving uninsured patients and Government beneficiaries to private sector bill payers." [20]

As cost containment and budget battles have taken their toll on Medicare, beneficiaries have been forced to pay for a higher proportion of costs of their health care. ICF, Inc., a private consulting firm, prepared an analysis for the American Association of Retired Persons on the role of Medicare in financing the health care of older Americans.[21] ICF found the following:

—The average elderly *household* will incur health expenditures (including health insurance premiums) of approximately $8,340 in 1986.

—Medicare will pay for almost 40 percent of households costs, and 45 percent of the average individual's costs. Medicare will pay for almost 60 percent of the costs of noninstitutionalized elderly and only about 20 percent for the elderly who are institutionalized.

—The average elderly household will pay approximately $2,670 for direct out-of-pocket payments and health insurance premiums.

—As a percentage of household income, the average elderly household will pay 11.6 percent of income on direct out-of-pocket payments and health insurance premiums in 1986.

In 1986, it is predicted that non-Medicare covered health care expenditures for prescription drugs for the noninstitutionalized elderly will be $8.5 billion. The noninstitutionalized elderly will also spend a total of almost $10 billion on dental care, eyeglasses and other professional and health services.

### (B) QUALITY OF CARE

When Congress enacted Public Law 98-21 establishing Medicare's prospective payment system, there was a general recognition that inherent in the newly structured payment system were incentives to underserve patients and discharge patients permaturely. To ensure against these outcomes, Congress charged the peer review organizations with monitoring for quality of care as well as utilization outcomes.

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[20] Meyer, Jack A. Passing the Health Care Buck: Who Pays the Hidden Cost, With William R. Johnson and Sean Sullivan. Washington, D.C., American Enterprise Institute for Public Policy Research, 1983, p.1.

[21] ICF Incorporated. The Role of Medicare in Financing the Health Care of Older Americans. Washington, 1985.

Nevertheless, PPS incentives to reduce costs and thus services were strong enough to raise fears that the health or lives of some Medicare beneficiaries would be endangered. After a year of implementation, many physicians and consumer groups representing the elderly began to grow concerned that PPS was posing serious threats to quality of care for Medicare beneficiaries, and might be eroding access to care for the sickest and oldest beneficiaries.

In early December 1984, the American Medical Association published the results of an informal survey of its members. A large majority of those who responded felt quality of care had already deteriorated, or would deteriorate as a result of PPS. The AMA survey reported that hospital administrators were encouraging physicians to discharge patients for a primary condition and readmit for a second; that there was pressure to release patients prematurely; and that practitioners were being asked to take a more critical look at the number of tests and procedures that they were ordering for their patients.

In February 1985, the General Accounting Office released to Senator Heinz and the Senate Special Committee on Aging, a preliminary report of a study on the impact of PPS on post-hospital care. The GAO report,[22] based on testimony from hospital, nursing home, and home health agency representatives from six communities around the Nation, indicated that patients were being discharged from hospitals "sicker and quicker" than before PPS and that in too many cases, were being discharged to inappropriate levels of care or no care at all. These findings were echoed in a joint hearing of the House Select Committee on Aging and the Task Force on Rural Elderly on February 26, 1985.

The administration, through the Health Care Financing Administration, countered these findings by claiming that "while there have been isolated instances of premature discharge and inappropriate transfer, there has been no evidence of systemic abuse"[23] HCFA argued that the watchdogs of quality, the peer review organizations (PRO's), were doing their jobs and that no major problems were developing.

As the agency with administrative and rulemaking responsibility for Medicare, HCFA is critical to the success or failure of the PRO program, the collection of data on quality and access under PPS and the overall operation of prospective reimbursement. But even in the light of increasing evidence of quality of care problems, HCFA repeatedly failed to acknowledge those problems or to take action to make the improvements needed in the statutes and regulations governing the PRO's.

### *(1) Effect of Prospective Payment on Quality*

In February 1985, the Senate Special Committee on Aging launched an investigation into quality of care under PPS. Committee staff visited and collected data from five PROs, and a number of community and university hospitals. The inquiry involved scores of interviews with Medicare beneficiaries, practicing physicians and nurses, university researchers, personnel from the Health Care Financing Administration, and the Department of Health and Human Services Office of Inspector General. In addition, committee staff gathered and analyzed volumes of records obtained from these organizations and individuals.

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[22] U.S. General Accounting Office. The Impact of Medicare's Prospective Payment System on Post-Hospital Care; Letter of February 21, 1985 to Senator John Heinz. Washington. 1985.

[23] Carolyne Davis, Ph.D., Administrator, Health Care Financing Administration. Testimony, U.S. Congress, Senate Committee on Finance, Subcommittee on Health. Hearing on Peer Review Organizations. 99th Congress, 1st Session. April 19, 1985. Washington, D.C. U.S. Govt. Print. Off. 1985. p. 51–52.

The committee's investigation led to three hearings in the fall of 1985: September 26, October 24, and November 12. The committee looked at quality of care issues in the hospital and post-hospital settings and heard witnesses from 14 States detail a large variety of problems with quality and access. The committee also heard from a wide-ranging set of experts on ways to respond to the various problems developing under PPS.

The committee found that quality of care problems are widespread, and that the PRO's feel hamstrung in their ability to perform their watchdog responsibilities. The most serious problems seem to be at the point of discharge from the hospital. Too often, hospitals discharge patients without regard to the appropriateness of post-hospital care.

Specifically, the committee looked at the nature and extent of quality of care problems, their causes, and possible solutions:

### *(a) Earlier discharge*

Patients are being discharged in a poorer state of health than before PPS. Case histories brought to the attention of the Committee on Aging revealed that medically unstable patients have been prematurely discharged.

### *(b) Denial of access*

Some hospitals have denied admission to patients with multiple serious conditions. Several physicians and hospital administrators described cases where patients deemed "DRG losers" were denied admission or inappropriately discharged from the hospital.

Experts testified that the DRG system does not account for differences in severity of illness. [Severity of illness refers to the fact that two patients with the same diagnosis may require different levels of care, particularly if one is older or there are other complicating conditions present.] As a result, equitable reimbursement—where hospitals are reimbursed adequately, but not excessively for patient care—cannot be assured under DRG's. This places the heavy-care patient in jeopardy of falling victim to a hospital's fear of finanical loss and being prematurely discharged, inappropriately transferred, or refused admission.

### *(c) Inadequate rights of appeal*

Many patients who may wish to present evidence of substandard care or challenge a discharge decision are unaware of their right of appeal, are given false or incomplete information regarding their right to appeal, or lack the necessary advocacy systems essential to appeal a discharge decision on their behalf.

Hospitals are required by law to "inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to PRO review and indicate the potential outcomes of that review"—i.e., that the PRO can deny reimbursement. This does not offer the beneficiary any explanation of how to appeal to the PRO as the agent of Medicare, authorized to ensure that Medicare does not pay too much, and quality is assured. There is also no standard language for hospitals to inform patients about DRG's and PRO's or about their rights to appeal. Not only is the information on exercising one's right practically nonexistent, but those substantive rights themselves are deficient. Current law contains too many loopholes through which hospitals can escape the responsibility of providing notice and appeal rights to beneficiaries.

### *(d) Pressures on physicians*

Some hospitals are pressuring doctors to treat patients in ways that violate good medical judgment in order to save money. For example, a physician from a Pennsylvania hospital testifed that his hospital had recently decided to warn doctors that their privileges could be jeopardized if their patients frequently overstayed the DRG average lengths of stay. A physician from California testified that one hospital he practices in has begun to pressure physicians toward quicker discharges by publicly ranking and comparing those physicians with longer and more costly patient stays to those with shorter moneysaving stays. Physicians' decisions to admit or not to admit patients for hospital care often have been based upon inflexible sets of DRG "cookbook" admission criteria.

### *(e) Limited scope of PRO's*

HCFA has focused the PRO's on a very narrow and incomplete set of quality issues, and therefore, HCFA's assessment of quality of care is grossly deficient. The PRO's existing contractual scope of review is limited to cases where the patient is readmitted to a hospital within 7 days. Thus, cases of readmission after 7 days or to hospitals outside the PRO area, deaths after premature or inappropriate discharge, denials of admission, inappropriate placement out of the hospital, and lack of adequate care in the community are not reviewed by a PRO.

Thomas Dehn, M.D., president of the American Medical Peer Review Association, testified that HCFA primarily wants data from the PRO's on utilization of stay—i.e., number of admissions, costs per admission, etc.—and is less concerned with quality review. AMPRA's report, "PRO's: The Future Agenda", dated September 1985 and prepared by their Task Force on PRO Implementation, states that: "The present quality assurance system required under PRO contracts is limited, restrictive, and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. Given the advent of prospective payment, no such data is available across a wide spectrum of in-patient care to the elderly. Only now are quality care concerns surfacing."

Existing Federal law does not permit PRO's to deny payment to a hospital or physician on the basis of poor quality of care. Under current law, when PRO's find a utilization problem (such as admission for a procedure that should have been done on an outpatient basis), they can unilaterally deny reimbursement under Medicare. However, when PRO's find a quality of care problem, no immediate action can be taken. Instead, they must refer it to the Secretary for an eventual decision on whether to seek repayment from the provider or exclude the provider from participation. Further, the PRO's are to report quality of care problems only if there is a pattern of substandard care or one particularly egregious instance.

*(f) Inadequate post-hospital care*

Large numbers of Medicare patients who are discharged quicker and thus sicker often find post-hospital care is unavailable or substandard. The stress on post-hospital services is substantially increasing. As GAO concluded from its survey of providers, "evidence of a trend toward increased use of home health services may not be showing up on early reports of the use of Medicare home health services that are based on hospitals' discharge data. . . . A large proportion of monthly hospital referrals to home health care (in one hospital, 89 percent of all discharges were to home health) were not showing up as discharges to home health care on the hospital discharge abstracts processed by the peer-review organizations."

GAO stated in its February 1985 report, that at each site they visited, "the view was expressed . . . that patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health than prior to PPS." Providers of post-hospital care confirmed to the committee that Medicare admissions to nursing homes have increased dramatically since DRG's began. These witnesses reported that "PPS has resulted in more and sicker patients being released into the community, often to the care of families who are not prepared or able to adequately care for them. . . . With the shorter length of stay and reduced staff in many hospitals, patients are often too sick to respond positively to educational efforts and nurses are too shorthanded to spend the extra time" needed to train the patient and the family to provide the care that will be needed at home.

Results of a committee investigation confirm data from HCFA internal reports which document a nearly 40-percent increase in discharges to skilled-nursing and home health care since October 1983. These data also demonstrate the inability of HCFA to estimate the rapid rise in the use of this benefit since the enactment of PPS.[24]

Only hospitals that voluntarily opt to have a Department of Social Work are required to meet Federal rules for discharge planning, and these rules have been criticized as inadequate by the National Association of Social Workers. HCFA plans to do away with even these lax rules. Existing hospital discharge planning programs—important mechanisms for assuring that patients are placed in appropriate community settings—are seriously overtaxed under PPS with the result that Medicare patients often receive inadequate post-hospital care.

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[24] U.S. Congress, Senate Special Committee on Aging. Committee Staff Report for Hearing on Medicare DRGs: Challenges for Post Hospital Care. 99th Congress, 1st Session. October 24, 1985. Washington. 1985.

Home health and nursing home care in the community is often unavailable. Testimony at an earlier hearing of the committee showed this shortage is aggravated by widespread illegal discrimination against Medicare and Medicaid eligible patients. Nursing homes prefer to take patients who will pay higher private rates as well as patients whose conditions are less costly to care for.

Community services are even less available when one looks at the quality of facilities. For example, more than 970 nursing homes have been chronically substandard for years, according to HCFA data, but these facilities still retain their certification to receive Medicare and Medicaid patients.

William Dombi, attorney from Legal Assistance for Medicare Patients in Connecticut, testified on October 24, 1985 that HCFA has "circumvented the law and subverted the intent of Congress . . . through oral and written policy directives, all designed to curtail home health and skilled nursing facility coverage." Mr. Dombi went further to assert that "there are two Medicare Programs, the one that is in the books under 42 USC section 1395 [and the one based upon the] directives of the Health Care Financing Administration." Other witnesses from the long-term care provider community confirmed that "patients cannot be admitted for care because of restrictive HCFA guidelines."

### *(g) Inadequate data*

According to the GAO, which testified at the November 12 hearing and updated the committee on its study of the impact of PPS on post-hospital care, DHHS lacks any statistically valid basis to confirm or deny the effect of DRG's on the quality of health care older Americans need or received upon discharge from the hospital. According to GAO testimony, DHHS does not have the necessary data to evaluate whether PPS has either increased or decreased the quality, access, demand, use or cost of post-hospital care for Medicare beneficiaries. Furthermore, DHHS is not planning to do the types of evaluations that are necessary to determine whether PPS is the cause of changes in these five areas.

There are, however, significant indications that these problems are more severe and widespread than current HCFA estimates. According to HCFA's own reports, between October 1, 1983, and May 31, 1985, 4,724 cases of suspected inappropriate discharges and transfers had been reported by the PRO's. Investigations by the DHHS Office of Inspector General confirm that these involved serious problems with substandard care, and that there were numerous cases in which there was little or no corrective action taken by HCFA or the PRO's.

### *(2) Unfit Health Practitioners*

Another concern relating to the quality of health care has been the effectiveness of Federal and State authority in regulating unfit health practitioners. As part of its ongoing efforts to safeguard the quality of care provided to Medicare and Medicaid recipients, the U.S. Senate Special Committee on Aging held a hearing in May

1984 to highlight serious defects in the ability of the Federal Government to protect the elderly and others from treatment by incompetent and dangerous medical practitioners. The problem stems from the limited authority possessed by the Secretary of the Department of Health and Human Services (DHHS) to exclude practitioners from participation in, and reimbursement from, the Medicare and Medicaid Programs.

Licensing of health care professionals is a responsibility of the States, and practitioners can, and often do, hold licenses in more than one State. State licensing boards are empowered to sanction practitioners for their improper actions related to any patient, and when the board suspends or revokes a practitioner's license, he or she can no longer legally provide services in that State.

In sharp contrast to this broad State power, DHHS has very limited authority to sanction practitioners. The Secretary is responsible only for practitioners' participation in Medicare and Medicaid, not for their other services, and can sanction practitioners or exclude them from Medicare and Medicaid only for specific acts committed against those two programs and their beneficiaries.

Because of DHHS limited exclusion authority, practitioners who are found by the Secretary to be unfit to participate in Medicare or Medicaid in a particular State, or are found by a State licensing board to be unfit to practice in that State, pose a threat to all Medicare and Medicaid patients. This is because they are able to relocate to another State in which they are licensed and set up another practice with no assurance that the problems which led to their sanctioning in the first State were corrected before they began treating Medicare and Medicaid patients in the other State. This situation was confirmed by a General Accounting Office (GAO) investigation which revealed that Medicare and Medicaid patients are being treated in some States by doctors and pharmacists who have been stripped of their licenses to practice in other States for reasons which do not justify national exclusion from Medicare and Medicaid under the Secretary's current exclusion authority. The GAO also identified a number of specific problem areas and gaps in the Secretary's exclusion authority.

### (C) REIMBURSEMENT PROBLEMS UNDER PROSPECTIVE PAYMENT (PPS)

1985 was the second full year for Medicare under prospective payment and the system was still experiencing many wrinkles. As the effects of PPS were being more fully realized by hospitals, pressures increased for various adjustments to the DRG's as well as for delays or changes to the schedule for the phase-in to national payment rates. In addition, indigent care, physician reimbursement, and capital payment reform emerged as major issues requiring futher action over the next few years.

Because payment adjustments under PPS are generally made within a budget neutral framework, most of the above are allocation rather than budget issues. Any adjustment will produce winners; it will also produce losers. Consequently, much of the debate over PPS changes tended to divide the hospital industry along regional and geographic lines. There were also major tensions between teaching and nonteaching facilities. Many of the issues were interrelated: the transition to national rates, changes in the area wage index, reimbursement for medical education all have a direct bearing on each hospital's Medicare payment. Congress addressed each of these issues in the context of deficit reduction and through the House and Senate budget reconciliation process. In fact, the only major vehicles for Medicare changes in 1985 were the budget reconciliation bills.

### *(1) Hospital Payment Issues*

#### *(a) Transition to national rates*

Current law provides for a 3-year transition from hospital specific costs to a fully phased-in national DRG payment rate in fiscal year 1987. This transition period was intended to provide time for finetuning of the prospective payment methodology. Hospitals that stand to lose money from the transition to national rates have worked to freeze or slow the transition, a position that is unpopular with the rest of the hospital community and with the administration.

The American Hospital Association has called for the replacement of the current transition to national rates with DRG-specific price blending. "Blending would increase the percentage of the hospital-specific rate, as opposed to the national average rate, in specific DRG's with a high degree of cost per case variation. In DRG's with smaller variation, payment would be weighted more heavily toward the national rate."[25] The intent of this plan is to ensure greater equity in payments to hospitals. Critics of the plan, however, argue that it would be extremely complicated and would undermine a principal objective of PPS, that is, achieving a Medicare payment system based on a uniform nationwide price for each DRG with as few adjustments as possible.

#### *(b) Area wage index*

The area wage index is an important element used in the calculation of the regional and national standardized DRG payments to hospitals. This was done to ensure that the DRG payments reflect differences in wages from area to area. To compute the initial wage index, HCFA used hospital wage and employment data maintained by the Bureau of Labor Statistics (BLS) of the Department of Labor. However, it is generally recognized that this data base does not accurately reflect differences among hospitals. The principal limitation of the BLS data—their inability to recognize local differences in the number of part-time hospital workers, was cited by a large number of hospitals, particularly rural midwestern facilities.[26]

Under the Deficit Reduction Act of 1984 (Public Law 98-369), HCFA was required to report to Congress on a refined wage index which was to be implemented retroactive to October 1983. In 1984, HCFA attempted to obtain better data on wage differences through a survey of hospitals, but the survey was hampered by a low response rate and questionable data quality.

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[25] American Hospital Association, Annual Meeting Issues Papers, unpublished draft, Washington, D.C. 1985, p. 2.

[26] U.S. Dept. of Health and Human Service, Health Care Financing Administration, Report to Congress on the Hospital Wage Index as required by section 2316(a) of P.L. 98-369. Washington, D.C. March 28, 1985.

The required report,[27] which was released to Congress in March 1985, proposed two alternatives. One wage index was derived from total gross hospital wages, which included salaries and wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers and hospital-based physicians. The other index excluded several variables from its calculation and was referred to as the adjusted gross index. On September 3, 1985, HCFA implemented a new wage index for discharges occurring on or after October 1, 1985. This index was based on the gross wage data from HCFA's 1984 survey. The rule also provided that the retroactivity required by current law would not come into effect until April 1, 1986. This was done to allow time for Congress to reverse the retroactive provision and for HCFA to develop a method to identify retroactive amounts.

### *(c) Graduate medical education*

Since its beginning in 1965, Medicare has reimbursed hospitals for its share of the direct costs of approved health professions education programs conducted in hospitals. These direct costs include salaries and fringe benefits for residents, faculty, and support staff; the cost of conference and classroom space in the hospital; any costs of additional equipment and supplies; and allocated overhead costs. Physician graduate medical education is the most costly component of health professions education paid under Medicare.[28] In fiscal year 1986, Medicare's payments to hospitals for the direct costs of graduate medical education are expected to be $1.3 billion.

Medicare also pays teaching hospitals an additional amount, called the indirect adjustment, to cover factors (including indirect teaching costs such as additional tests ordered by residents) that are believed to result in higher costs in teaching hospitals than in nonteaching hospitals. Medicare's payments for indirect teaching costs are expected to be $1.4 billion in fiscal year 1986. In total, Medicare will spend $2.7 billion on medical education in fiscal year 1986. Medicare is the single largest payer for health professions education in hospitals.[29] When the Medicare Program was established, Congress was clear in its intent that Medicare should support the clinical training of health personnel. As a result of Medicare payment policies and additional Federal support of the health professions through NIH and title VII of the Public Health Service Act, a vast network of medical and health profession schools developed throughout the country.

This growth in medical education has helped ease what was once a substantial physician shortage to the point where many now argue that we are in danger of having too many physicians by the end of the decade. According to a report by the Graduate Medical Education National Advisory Committee (GMENAC) published in 1980, there will be 70,000 excess physicians by 1990 and 145,000 excess physicians by 2000.[30] A 1984 study by DHHS has predicted an excess of more than 35,000 physicians by 1990 and about 51,000 by 2000.[31] However, while in the aggregate there may be too many physicians, a physician shortage will exist for certain specialty areas such as psychiatry and primary care specialists.

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[27] Ibid.

[28] U.S. Library of Congress, Congressional Research Service, Background Paper for use of the Members of the Senate Finance Committee on Payments for Medical Education by the Medicare Program. Washington, D.C. May, 1985.

[29] Ibid.

There is also evidence that there remain a large number of medically underserved areas in the Nation, indicating that excess supply does not directly alleviate maldistribution problems, especially in poor inner-city neighborhoods and remote rural areas. The DHHS and GMENAC reports also reinforce growing concerns about the appropriateness of continued Medicare funding for foreign medical graduates (FMG's). On the one hand, FMG's have helped alleviate shortages in some geographical areas; on the other hand, they are viewed as feeding the physician glut.

With mounting pressures on the Medicare hospital insurance trust fund, the growing Federal deficit, and the increased supply of physicians, the administration and many in Congress have begun to question whether Medicare's payments for graduate medical education should be continued. Direct payments for medical education are especially problematic because they are still paid on a pass-through or open-ended basis, that is, the incurred costs of approved programs are reimbursed regardless of the nature and costs of the program.

Nevertheless, indirect payments are also a target for cuts because they are seen as too generous. The indirect adjustment serves as a proxy for other factors that are not adequately recognized by DRG's but that may increase costs in teaching hospitals which traditionally treat sicker patients. These include higher case severity, greater intensity of service, and in some cases, disproportionately large amounts of uncompensated care. In 1983, with the implementation of DRG's, Congress decided to apply a doubled indirect medical education adjustment to the DRG's to substitute for those factors noted above. DHHS claims that the indirect adjustment is unjustified. According to HCFA, there is no empirical evidence to support the doubling of the adjustment. It therefore makes sense to return the adjustment to its original level.

In response to these and other concerns, various proposals have been offered to change the way in which Medicare pays hospitals for health professions education. In the administration's fiscal year 1986 budget, a freeze on direct graduate medical education payments was proposed. In addition, the administration called for a 50-percent reduction in indirect payments. Together, these measures would have produced a 31-percent reduction in Medicare support for graduate medical education. They drew instant criticism from the American Association of Medical Colleges (AAMC) and its member institutions which recommended against the freeze. In its place, AAMC urged that Congress amend DRG's to reflect heavier hospital-specific weighting in the payment formula. This set the stage for a heated debate in Congress over the future of Medicare's support for graduate medical education.

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[30] U.S. Dept. of Health and Human Services. Summary Report of the Graduate Medical Education National Advisory committee to the Secretary. Washington, D.C. September, 1980.

[31] U.S Dept. of Health and Human Services. Report to the President and Congress on the Status of Health Personnel in the United States. Excutive Summary, Washington, D.C. May, 1984.

### *(d) Medicare and uncompensated care*

Traditionally, the public-private patchwork of health insurance coverage has afforded basic protection to a majority of Americans. However, today there are 35 million Americans who find themselves without health insurance. Of these, 5.5 million are age 45 to 54 and 2.9 million are age 55 to 64. Surprisingly, even 389,000 persons over the age of 65 are without insurance of any kind even though the common perception is that the elderly are taken care of by Medicare and Medicaid.[32]

The number and proportion of the uninsured is increasingly substantially. The number of uninsured nonaged persons, the only group for which trend data are currently available, increased by 20.4 percent from 1979 to 1983.

Prior to the last recession, the problem of the uninsured was viewed as a problem of the very poor, and those individuals who had seasonal, part-time, or low-skilled jobs, in which employers generally did not provide health insurance coverage. Most working Americans received health insurance through their or their spouse's employer. Others were protected by public insurance programs or their costs were picked up by health care providers who subsidized nonpaying patients by shifting these "bad debts" and "uncompensated care" patients to other payers.

But during the last recession, 10.7 million Americans lost their admission tickets to the health care delivery system. These people lost health insurance protection when they or their family's head of household lost their jobs. Since that time, the system of health care protection has changed radically. Cutbacks in Medicaid and other public programs have caused cracks in those sources of health care which directly serve America's uninsured. In addition, the changing nature of America's health care, with reforms in reimbursement, heightened competition and the growth of for-profit medicine, is making it increasingly difficult for the uninsured and the underinsured to obtain even emergency access to health care.

Before prospective payment, many hospitals were able to shift the burden of providing high levels of uncompensated care to Medicare and other payers, such as Blue Cross. Under PPS and the threatened ratcheting down of Federal payments, as well as tightening reimbursement policies among private payers, hospitals are increasingly reluctant to take patients for whom there is no guarantee of reimbursement. The shrinking number of hospitals that do take large numbers of low-income patients argue that such patients are generally sicker and require greater intensity of services. To the extent that these hospitals are bearing a disproportionate burden of such patients, they assert that they should be receiving a reimbursement which reflects this special burden.

*Disproportionate share hospitals.*—Legislation addressing disproportionate share hospitals (DSH's) was first enacted as a provision in the Tax Equity and Fiscal Responsibility Act of 1982 (Public

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[32] U.S. Congress, Senate Special Committee on Aging, Americans at Risk: The Case of the Medically Uninsured. Background Paper Prepared by the Staff. Washington, D.C. June 27, 1985.

Law 97-248) which established the foundation for Medicare's PPS. The Secretary of DHHS was required to provide for exemptions from, and adjustments to, the cost limits then in effect for Medicare reimbursement to hospitals. HCFA did not implement the provision because, as was indicated in regulations, it did not have the data to determine the extent to which special consideration for such hospitals was warranted or the type of provision that might be appropriate. A similar provision of DSH's was included in Public Law 98-21, the measure creating Medicare's PPS. Under this act, the Secretary was charged with developing a methodology for a DSH adjustment to the DRG's. Again, HCFA indicated in regulations that it would not implement the provision in fiscal year 1984 or fiscal year 1985 because it did not believe that it had the evidence to justify the adjustment. In Public Law 98-369 (the Deficit Reduction Act of 1984), Congress required the Secretary to develop a definition of disproportionate share hospitals and to identify such hospitals by December 31, 1984. HCFA is still working to fulfill this requirement.

The special needs of DSH's have been the subject of much debate and has greatly influenced congressional action so far. Special needs could be interpreted to include a broad array of specific problems found in hospitals serving low income or Medicare patients, ranging from potentially higher costs of treating patients that are more severly ill to the cost of providing uncompensated care. Generally, they have been interpreted more narrowly. Thus, the costs of additional services and more costly services that may be required to meet the needs of low income or Medicare patients would be included only to the extent that such costs result in higher Medicare operating costs per case in hospitals serving disproportionate numbers of such patients. Moreover, the possibility of additional payments to hospitals under Medicare for such costs as uncompensated care have been excluded, usually on the grounds that section 1861(v) of the Social Security Act specifically prohibits Medicare from paying for the costs of services provided to persons not entitled to benefits under the program.[33]

On April 1, 1985, the Prospective Payment Assessment Commission, which was mandated by Public Law 98-21 to advise the Secretary and Congress on PPS issues, recommended that a DSH provision be included in fical year 1986 PPS rates.[34] Armed with this recommendation, and frustrated by HCFA's inaction, the House Ways and Means Committee decided to come up with its own adjustment, and included a provision in its deficit reduction package. In response to a court order from the U.S. District Court for the Northern District of California, resulting from the lawsuit of a small California rural hospital, HCFA published proposed rules implementing the DSH provision on July 1, 1985 (*Redbud Hospital District* v. *Heckler*). However, HCFA made clear that it would award such an adjustment only in extraordinary cases and only after a case-by-case review. HCFA also appealed the decision.

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[33] U.S. Library of Congress, Congressional Resrearch Service. Medicare Payment Provisions for Disproportionate Share Hospitals. Background Paper. Pepared for the use of the Members of the Committee on Finance, Washington, D.C. July 1985.

[34] U.S. Dept. of Health and Human Services, Prospective Payment Assessment Commission, Report and Recommendations to the Secretary. Washington, D.C. April 1, 1985.

### *(e) Hospital capital costs*

The issue of how Medicare pays for hospital capital costs was expected to be a major issue in 1985, but was left to the 1986 agenda when HHS failed to deliver the congressionally mandated report, and other Medicare issues emerged. Under current law, hospitals are reimbursed on a retrospective cost basis for their expenditures for equipment and facilities, including depreciation costs, and return on equity. The passthrough of capital costs has encouraged hospitals to make capital investments, whether or not those investments are justified in terms of the needs of their communities. In 1984, Medicare paid about $3.2 billion for capital-related costs.

Under Public Law 98-21, if Congress does not pass legislation bringing capital payments under prospective payment by October 1, 1986, all States will have to review hospital capital expenses under the section 1122 program, something almost no one favors. The administration was supposed to deliver a report on capital payment options by October 1, 1984, but the report was still under OMB review in December 1985. A capital payment plan is, however, expected to be incorporated in the administration's fiscal year 1987 budget proposal. The plan is likely to produce substantial savings in capital expenditures in Medicare by providing for a capital add-on to the DRG's of a specified percentage. According to early reports, the new system would be phased in over a 5-year period in five even steps. In fiscal year 1987, 20 percent of capital payments would be based on a national prospective rate, while 80 percent would be based on hospital-specific capital costs. The split would move to 60-40 in fiscal year 1988, 40-60 in fiscal year 1989, 20-80 in fiscal year 1990, and 100 percent national rate in fiscal year 1991. Return on equity payments to proprietary hospitals and funded depreciation offset payments to voluntary hospitals would not be included in the national portion.

## *(2) Physician Payment*

Medicare's expenditures for physician services increased at an annual rate of 20.6 percent over the fiscal years 1979-83 period. While reduced inflation and the fee freeze have curbed the rate of increase, physician payments are still on the rise, fueling the desire of the administration and Congress to reform the payment system.

Since 1983, the principal strategy for holding down expenditures has been the physician fee freeze and the participating physician program, neither of which were intended as long-term reforms. However, serious consideration of more fundamental changes has been hampered by a number of factors. These include major gaps in the data on what the program is currently paying for, opposition by a number of physicians to a major alteration in the fee-for-service/voluntary assignment approach, and the uncertainty concerning the actual impact of the major reform options on both the program and beneficiaries. However, with the increasing need to curb costs and the vast innovation and change occurring in the organization of physician practice, pressures for comprehensive reform are likely to mount.

The major alternatives which are being discussed include fee schedules, paying for physicians' services on the basis of DRG's, or paying for services on a capitation basis. Studies of a number of options are currently being conducted by HCFA, the Office of Technology Assessment, and other public and private entities.

*(a) Physician payment options*

*Fee schedules.*—The current de facto fee schedules based on local prevailing charge patterns would be replaced by a uniform fee schedule for all physicians' services. One way to do this would be to use a relative value scale (RVS), which is a method of valuing individual services in relationship to each other. Each service is assigned an abstract index or weight and other services are assigned higher or lower numbers to indicate their value relative to that service. The use of RVS could make the payment system more sensitive to a physicians' time, skill, overhead costs, and the complexity of the service. An RVS is not a fee schedule. However, it is translated into a fee schedule by use of a predetermined conversion factor. The drawback to RVS is that its complexity is such that a workable system may be difficult to develop.

Fee schedules would rationalize the current payment system and place limits on payments for individual services. The key issue is the payment unit. It needs to be designed so that physicians are unable to manipulate the system by increasing or unbundling services or upcoding (coding for a procedure that is reimbursed higher than one actually delivered).

*Physician DRG's.*—Under the Social Security Act Amendments of 1983, DHHS was required to report to Congress by July 1985 on the feasibility of paying for physicians' services provided to hospital inpatients on the basis of DRG's. DHHS has not yet given Congress the report.

It is expected that a physician DRG payment scheme for inpatient services would involve the establishment of a predetermined rate for each of the 471 DRG's used under the PPS system. The major advantage of this scheme is that it would establish a specified payment amount for all services provided during an inpatient stay. There are, however, numerous questions about the practicality and appropriateness of a DRG scheme for physicians. The existing DRG system is based on resource use in hospitals; it may not be an accurate measure of physicians' input costs. Another issue is who is going to receive the payment—the hospital, the attending physician, or the medical staff? One consideration in making this determination is the degree of financial risk imposed on the various parties involved. For example, an individual physician's caseload may consist of a higher proportion of sicker patients requiring more intensive care than the average for a particular DRG. Placing an individual physician at risk could potentially encourage the provision of less care than was medically appropriate or the avoidance of more severe cases.

Another issue is the potentially dangerous alignment between hospitals and physicians under a DRG payment scheme. Under the existing system, the physician is the last remaining check on quality. If he or she is given the same incentives as the hospital to reduce care, then quality may grossly deteriorate. Other issues involve potential gaming—multiple admissions to maximize reimbursement; shifting care to the outpatient setting, etc.

*Capitation.*—Medicare would contract with an entity such as a carrier, which would serve as an at-risk insurer in a defined geographical area. Medicare would essentially purchase a specified package of services for a specified per person price. The entity would be responsible for determining payment amounts and payment units. To assure beneficiary access to care at predictable levels of out-of-pocket costs, an entity could be required to obtain physician participation agreements from a certain percentage of physicians in the geographic area. The Federal Government would be required to determine the per capita (per person) payment amount. The system could be designed to be mandatory for all beneficiaries or optional.

*Administration's voucher plan.*—The administration is seeking to use a combination of vouchers and capitation; it has backed off from DRG-based payments and uniform fee schedules based on relative value scales. Under the proposal, called the Medicare Voucher Act of 1985, the Government would make single payments (eg, 95 percent of the per capita payment for Medicare—estimated to be around $200 per month) to an entity (health benefit organization), such as a private insurance company, to cover all physician services both in and out of the hospital. The idea is based on the HMO model. The theory is that if every Medicare patient is given the *option* of joining such a plan, doctors' groups, HMO's, and insurance and medical groups would compete to offer the best plans at the lowest costs, holding prices down while providing the required range of services. The insurers could keep the difference if the beneficiary's health care costs were less than the Federal payment. The insurers would have to absorb any costs above the payment. There would be an open season once a year for beneficiaries to elect plans and they would not have to pay more than they do now for copayments and deductibles.

There are many questions about the effects of such a proposal and it is likely to be heavily scrutinized by Congress and organizations representing the elderly. Initial concerns include whether beneficiaries will have the information and knowledge to make rational selections among the various plans. There is also a question of skimming and adverse risk. The healthier beneficiaries may opt for the capitated scheme leaving the basic Medicare Program to absorb the high cost, heavy care patients. Finally, there is a concern that the administration will be driven by budget concerns to hold the capitation payments low and to pare down the required benefit package.

### (D) MEDICARE AND HMO'S

While the theory behind HMO's sounds very promising, the Medicare HMO program to date has not been completely smooth in operation. In March 1985, the General Accounting Office (GAO) produced a report on the problems in administering Medicare's HMO demonstration projects in Florida. That report was prompted by beneficiary inquiries and complaints concerning the HMO's. During its investigation, GAO found that most of the problems were related to: (1) The recording of the enrollment and disenrollment of Medicare beneficiaries in the HMO's, and (2) the administration of the lock-in features of the HMO projects.

Under Federal law, it is now required that, except for emergency or urgently needed services, all health care for Medicare beneficiaries enrolled in a HMO must be provided or authorized by the HMO's. This requirement is referred to as the lock-in provision and any related services obtained by beneficiaries without the HMO's authorization are referred to as out-of-plan services for which the beneficiary is financially responsible.

GAO found that most beneficiaries appear to understand the HMO lock in provisions and the need to obtain prior authorization for nonemergency medical services outside of the HMO's to which they belong. However, it found that the system for coordinating the HMO's operations with Medicare's administrative structure, particularly during beneficiary enrollment periods, is vulnerable to duplicate or other erroneous payments to the HMO's, hospitals, physicians, or beneficiaries, such as Medicare paying for services that an HMO had already been paid for. Many of the errors identified occurred because beneficiary HMO enrollment dates were not recorded until long after the enrollment became effective. This led to incorrect determinations as to who should pay medial expenses—the HMO or the regular Medicare Program. Further, the program's regulations and procedures do not clearly spell out the financial liability of a beneficiary who undergoes hospitalization during the waiting period between the date they apply for enrollment and the effective date and is still hospitalized on the effective date of HMO enrollment, or a beneficiary who receives necessary medical services during the waiting period between the date he or she applies for disenrollment and the effective date.

Many unanswered questions remain about the HMO concept and its utilization by Medicare beneficiaries: Whether risk-based contracts can contain costs without jeopardizing the quality of care or leading to underservice, whether they can achieve a slower growth in health care costs than other types of health care delivery programs, whether beneficiaries understand the restrictions they accept when they enroll in a HMO, and so on. More attention will most likely be paid to these questions in the future: If the current 15 percent annual growth rate of people enrolled in HMO's continues, one-half of the U.S. population will belong to an HMO by 1995.

## 3. LEGISLATION AND REGULATIONS

### (A) COMPREHENSIVE COST-CONTAINMENT LEGISLATION

In 1985, there was little movement toward any comprehensive reforms of the Medicare system. The interest in proposals like Kennedy-Gephardt (H.R. 1801; S. 1346) and the Medicare Incentives Reform Act (S. 2752), introduced by Senator Heinz in the 98th Congress, diminished with the announcement of the Medicare trustees that solvency was assured at least through the end of the decade. As a result, the administration and the Congress limited their actions to marginal cost-saving alterations in Medicare which were proposed and legislated in the overall context of deficit reduction.

## (B) ADMINISTRATION FISCAL YEAR 1986 BUDGET PROPOSALS

In 1985, cost containment was again translated principally into efforts to slow the increase in Medicare outlays. Program growth can be checked by reducing eligibility, reducing benefits, or increasing beneficiary cost-sharing. The administration's Medicare budget proposal for fiscal year 1986 incorporated all three strategies.

The administration's fiscal year 1986 budget for Medicare reflected its overall theme for curbing Government spending to reduce the Federal deficit. For fiscal year 1986 alone, the proposals would have resulted in over $4.2 billion in savings from current services; over the 5 years fiscal years 1986–90, the proposals were estimated to save the Medicare Program over $42 billion. Even with these cuts, Medicare outlays were predicted to increase from about $71 billion in fiscal year 1985 to over $100 billion in fiscal year 1990.

### *(1) Provider Cuts*

The administration estimated that the largest part of its Medicare savings (79 percent) would come from changes affecting health care providers, 12 percent would come from changes affecting the private sector and 9 percent would come from changes directly affecting beneficiaries. These figures reflect only the impact from reduced outlays. If increased costs to beneficiaries resulting from the increase in the part B premium were included, the portion borne by the beneficiary rose to 33 percent.

The provider savings were to be achieved primarily through a 1-year freeze on reimbursement rates or limits. Additionally, some savings were to be achieved by revising the calculation of reimbursement amounts. Most of the freezes with the exception of those affecting physician payments and laboratory fees would have been achieved through regulatory changes rather than through legislation. While many in Congress were concerned that DHHS was inappropriately assuming regulatory authority over such matters as DRG payments to hospitals, DHHS asserted that Congress had given it such authority under Public Law 98–21, the Social Security Act Amendments of 1983, which created the Medicare Prospective Payment System.

*Hospital payments.*—The majority of provider savings were to result from limits on hospital payments, principally a 1-year freeze on PPS payment rates. (See table *6* for a list of the administration's proposals.) The Department stated that, given the currently available information about recent productivity gains in the hospital industry, it believed that the PPS payment rates in effect for fiscal year 1985 would be sufficient for fiscal year 1986. The basis for this assumption was that productivity gains have been reflected nationally in recent declines in the intensity of services (i.e., number of services provided per stay), the decrease in the average length of stay, and the declines in employment levels. Critics responded that some of the productivity gains by hospitals merely reflect the transfer of certain services (and therefore costs) to ambulatory or other institutional settings not covered by PPS. Moreover, reduced Medicare payments could result in diminished quality of care and the imposition of barriers to access for certain heavy-care patients.

## TABLE 6.—ADMINISTRATION ESTIMATE OF THE IMPACT OF ADMINISTRATION FISCAL YEAR 1986 PROPOSALS ON FEDERAL MEDICARE OUTLAYS

[In millions of dollars]

| | Fiscal year— | | | | | Total 1986–90 |
|---|---|---|---|---|---|---|
| | 1986 | 1987 | 1988 | 1989 | 1990 | |
| Current program | 77,194 | 85,349 | 55,011 | 105,719 | 117,452 | |
| A. Proposed regulatory changes: | | | | | | |
| 1. Freeze prosp. payment rates | −1,800 | −2,491 | −2,548 | −2,809 | −3,085 | −12,733 |
| 2. Freeze limits for PPS-exempt hosps. | −20 | −30 | −35 | −45 | −55 | −185 |
| 3. Freeze direct med. ed. pymts. | −150 | −360 | −530 | −730 | −940 | −2,710 |
| 4. Restructure home health limits | −70 | −90 | −95 | −105 | −120 | −480 |
| 5. Freeze SNF limits | −5 | −5 | −5 | −5 | −5 | −25 |
| 6. Freeze durable med. equip. pymts. | −50 | −100 | −150 | −200 | −250 | −750 |
| Subtotal, regulatory changes | −2,095 | −3,076 | −3,363 | −3,894 | −4,455 | −16,883 |
| B. Proposed legislation affecting outlays: | | | | | | |
| 1. Freeze phys.fees | −500 | −425 | −350 | −425 | −525 | −2,225 |
| 2. Init. elig. delay | −225 | −305 | −330 | −365 | −400 | −2,625 |
| 3. Index Part B ded. | | −75 | −150 | −250 | −350 | −825 |
| 4. Voluntary Medicare voucher program | | +50 | +50 | +50 | +50 | 200 |
| 5. Elim. doubling ind. med. ed. pymts. | −695 | −1,115 | −1,430 | −1,595 | −1,760 | −6,595 |
| 6. Home health copymts. | −65 | −115 | −125 | −135 | −150 | −590 |
| 7. Freeze reimburs. to clinical labs | −35 | −100 | −325 | −455 | −605 | −1,520 |
| 8. Working aged 69+ | −295 | −450 | −515 | −570 | −640 | −2,470 |
| 9. Part A claims proc. | −3 | −4 | −4 | −4 | −5 | −20 |
| 10. RRB contractor | −2 | −2 | −2 | −2 | −2 | −10 |
| Subtotal, legislative changes | −1,820 | −2,541 | −3,181 | −3,751 | −4,387 | −15,680 |
| Total, Medicare | −73,279 | −79,732 | −88,467 | −98,074 | −108,610 | |
| C. Proposal Affecting Income: 1. Incr. Part-B prem. | +332 | +927 | +1,992 | +3,318 | +4,928 | +11,497 |

Source: HCFA, unpublished tables.

The impact of such a freeze would vary by hospital. Large urban hospitals in large metropolitan areas are more likely to be hurt than some other institutions. This is because these hospitals tended to have higher costs than average at the start of the PPS program. Further, these institutions tend to be large Medicare providers. Some small rural hospitals are also likely to be hit hard in certain regions of the country.

The administration also proposed a 1-year freeze on reimbursement limits applied to hospitals exempt from PPS. This freeze was consistent with that proposed for other providers. However, the freeze may have a greater impact on non-PPS hospitals since they have not had the same incentives for productivity gains under the reimbursement limits as have hospitals under PPS.

*Medical education.*—The administration also proposed two changes in the way Medicare pays for its share of medical education costs. The first, a permanent freeze on direct medical education costs would mean that Medicare's share of payment for such costs will decline over time. The administration also proposed to eliminate the doubling of the indirect medical adjustment factor. According to DHHS, there was no empirical justification for doubling the payment. However, the teaching adjustment was originally doubled by Congress in order to offset any weaknesses of the DRG's in adjusting for the systematically higher levels of severity of illness anticipated in the teaching hospitals. It was also to act as a surrogate for an adjustment for high levels of indigent and Medicare patients.

*Physicians payments.*—For part B, the administration proposed to extend the freeze on physicians' fees for an additional year. Many physicians who agreed to become participating physicians under the DEFRA provisions felt that the proposal meant the Government was turning its back on them by continuing the freeze for another year. Some argued that this proposal would not produce savings because it would freeze only payments for individual service units and would not include controls on volume. Several studies have shown that when limits are placed on allowable fees for individual units of service, physicians respond by increasing the volume of services and changing to a more complex service mix.

### *(2) Beneficiary Proposals*

The administration's budget contained several proposals to directly increase individual beneficiary payments. Several of these were recycled from previous administration budgets. These proposals were intended to maintain the level of beneficiary contributions to the costs of care, and with respect to home health services, make them cost conscious in the use of services. Opponents argued that beneficiaries are now facing large out-of-pocket expenditures in connection with their medical care. In 1985, America's elderly would each spend on average $1,660 for health and long-term care—over 15 percent of their already limited incomes. Indeed, 1985 marked the first year in which the elderly spent more for their health care than they did when Medicare and Medicaid began.[33]

*Part B premium increase.*—The proposal to gradually increase the part B premium to cover 35 percent of program costs would have cost beneficiaries an additional 70 cents per month in 1986. The proposals to index the annual part B deductible and to impose coinsurance on home health visits would have also transferred some of the costs of covered Medicare services directly from the program to beneficiaries. Indexing the part B deductible would have increased it by $3 in 1987, which would have affected approximately two-thirds of the enrollees who reach the deductible. The proposal was intended to make the deductible, which is currently at a flat rate of $75 increase with rising program costs.

*Delay eligibility.*—The proposal to delay the date of initial Medicare eligibility by 1 month would have shifted program costs, either to older individuals or to employer-based health insurance plans that now may cover such persons up to age 65 or until they are eligible for Medicare. Thus the administration argued that the initiative would not result in a gap in insurance coverage since nearly all employer-based health plans generally extend protection until the beginning of Medicare coverage. This assumption has to be questioned, however, given the many pre-Medicare eligible who find themselves with gaps in coverage.

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[33] U.S. Congress, House Select Committee on Aging. America's Elderly at Risk. Report presented by the Chairman, Committee Print, 99th Congress, 1st Session. Washington, U.S. Govt. Print. Off. July 1985, p. vii.

*Medicare as secondary payor.*—The proposal to make Medicare the secondary payor for working persons and their spouses over age 69 would also shift program costs to employer-based health insurance plans. The precedent for this approach has already been set for the age 65–69 group. The proposal could potentially increase employer health insurance premium costs for this age group. Thus employers may become less willing to hire the over-69 age group who now are not protected by the Age Discrimination in Employment Act.

*Voucher.*—The administration also proposed legislation for a Medicare voucher plan to permit beneficiaries, at their option, to seek private alternatives to Medicare coverage. The administration described the proposal as building on the provisions in TEFRA for HMO's and competitive medical plans (CMP's). Advocates for the voucher concept argued that such an approach would foster greater competition in the provision of health services to Medicare beneficiaries as well as moderate increases in health spending for the target population. Critics expressed doubts that the kinds of insurance incentives envisioned as part of such plans would in fact have much impact on either the cost or use of health services, especially among the higher risk aged and disabled population who are likely to retain their enrollment in the basic Medicare Program.

As detailed later in this chapter (see Legislative Activity), both the House and the Senate were quick to pare down the scope and magnitude of the proposed cuts in Medicare. Medicare had already absorbed about $30 billion in cuts between 1981 and 1985, and as noted above, beneficiaries were shouldering an increasingly large financial responsibility for their health care. Congress was reluctant to place additional financial burdens on the elderly by achieving Medicare cuts through cost-shifting. It is therefore not surprising that the administration found more support in Congress for provider cuts than for cuts that would directly affect beneficiaries.

Medicare's fiscal year 1986 budget was considered as part of the 1986 budget resolution (S. Con. Res. 32), and then as part of the Consolidated Omnibus Budget Reconciliation Act for 1986 (S. 1730, H.R. 3128, Conference Report H. Rept. 99-453). As of this writing, the House and Senate have been unable to agree upon the conference report, and on December 20, 1985 the Senate asked for a new conference. Because of the failure to pass reconciliation, Congress passed an emergency extension act (Public Law 99-201) extending 1985 law for DRG payment rates and rules until March 15, 1986. It also continues the physician fee freeze until March 15, 1986. Should Congress pass the reconciliation conference report, Medicare will experience a cut of about $11.2 billion over 3 years.

### (C) CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

Congress sought a number of changes in the Medicare Program to achieve savings through the budget reconciliation process. A total of $11.2 billion in savings would be achieved through passage of the conference report for H.R. 3128, the Consolidated Omnibus Budget Reconciliation Act (H. Rept. 99-453). Stalemated over a provision relating to the toxic waste dump Superfund, the Senate sent the bill back to conference on December 20, 1985, just before the end of the first session of the 99th Congress. Should reconciliation be passed with the same Medicare provisions, the following additional Medicare changes will result:

### *(1) Raising Revenues for the HI Trust Fund*

Several unsuccessful attempts were made in the House and the Senate to designate a portion of the tobacco excise tax to the HI trust fund. It was decided, however, not to earmark any of these revenues but instead, place them in the general Treasury. Congress did, however, provide for the extension of Medicare coverage to certain employees of State and local governments. Under the conference agreement, Medicare coverage would be extended on a mandatory basis to State and local government employees hired after December 31, 1985. These employees would be liable for the hospital insurance portion of the FICA tax. In addition, a State may extend Medicare coverage to State and local government employees hired prior to 1986 by voluntary agreement with the Secretary of Health and Human Services.

### *(2) Provisions Affecting Hospitals*

#### *(a) Hospital rate of increase*

Hospitals would be given a 1-percent increase in DRG payments as of March 1, 1986; until then rates would remain frozen at the fiscal year 1985 levels. In fiscal year 1987 and fiscal year 1988, rates would be increased by a maximum of the rise in the value of the marketbasket of hospital goods and services (0.25 percent lower than the current formula). Savings are estimated at $6 billion in fiscal years 1986–88.

#### *(b) Transition to national DRG rates*

The House included a 1-year freeze in the transition in its deficit reduction package (H.R. 3128), which would have held the schedule at 50 percent hospital specific and 50 percent Federal DRG rate (a combination of regional and national rates). The Senate did not include any changes in its deficit reduction package (S. 1730). The conference report agreed upon as of December 20, 1985, included a modification of the House provision: The split between national DRG's and hospital-specific DRG's would be held at 50–50 from October 1, 1985, to March 1, 1986. From March 1, 1986, to October 1, 1986, the split would be 55 percent national and 45 percent hospital-specific; from October 1, 1986, to October 1, 1987, the split would be 75–25 and on October 1, 1987, rates would be 100 percent national.

#### *(c) Area wage index*

In Congress, there was substantial concern on the part of many Members from Midwest States about the need for a modified wage adjustment. The existing adjustment penalized most severely those hospitals classified as rural but situated in areas where the wages were paid on urban levels. In addition, Members were concerned about the financial hardship on those hospitals which would experience reduced payments as a result of a revised wage index, especially if the reduction was applied retroactively. Various bills were introduced to change the wage index, including H.R. 3210, introduced by Representative Stark, H.R. 2819, introduced by Representative Daub, S. 1376, introduced by Senator Grassley, and S. 1096, introduced by Senator Exon.

The House included in its deficit reduction package (H.R. 3128) a provision requiring the implementation of the gross wage index effective October 1, 1985. The Secretary would be required to report to Congress on refining the adjustment to reflect higher wage costs incurred by core city areas relative to suburban areas of the same metropolitan area. The Senate's deficit reduction package (S. 1730) required implementation of the gross wage index as well, making the provision effective October 1, 1985. Under the conference report, new revised area wage indexes would be applied as of March 1, 1986. The requirement that the indexes be applied retroactively to October 1, 1983, would be repealed.

### *(d) Disproportionate share*

Hearings on disproportionate share hospitals were held in the Senate Finance Committee's Subcommittee on Health on July 29, 1985. The issue was also a central focus of the Ways and Means Committee hearings on the fiscal year 1986 budget. In addition, the Senate Special Committee on Aging held a hearing on June 27, 1985, on problems of the medically uninsured which provided substantial evidence on the need for Congress to provide a disproportionate share adjustment and related issues.

*Bills introduced.*—A disproportionate share adjustment was proposed by Senators Dole and Durenberger in S. 1606, introduced on August 1, 1985. A revised version of this bill was incorporated in the Senate's deficit reduction package (S. 1730). A very different adjustment was proposed by Representative Stark and Senator Kennedy (H.R. 3210; S. 1614) and became the basis of the House Ways and Means disproportionate share adjustment in H.R. 3128.

Under the Ways and Means Committee bill (H.R. 3128), the Secretary is required to make additional payments to urban PPS hospitals with 100 beds or more serving a disproportionate share of low-income patients. The Federal payment would be increased by 7 percent for each 10 percentage point increase in the proportion of Medicaid days to total days, above the minimum threshold of 15 percent. The maximum adjustment would be 16 percent. A limited exceptions process would be established for urban hospitals with 100 or more beds. The Secretary would be required to make disproportionate share payments of 16 percent per DRG where a hospital can demonstrate that 340 percent of its revenue is provided by local or State governments for low-income persons not covered by Medicare.

Under the Senate bill (S. 1730), the Secretary of HHS would be required to make additional payments to all hospitals serving a disproportionate share of low-income Medicare patients. The proxy measure would be the percentage of a hospital's total Medicare patient days attributable to Medicare patients who are also enrolled in the Federal Supplemental Security Income (SSI) program. Hospitals with over 100 beds serving a disproportionate share of low-income patients would receive an adjustment in relation to their proxy measure but not to exceed 12 percent. Hospitals with less than 100 beds would receive a 12-percent adjustment if their proxy measure is over 55 percent.

*Conference agreement.*—The House-Senate Conference Committee agreed to the following: Hospitals that serve large numbers of low-income patients would receive an adjustment of up to 15 percent in their DRG payments. The legislation includes a formula to determine eligibility based on total days attributable to Federal SSI beneficiaries as a percentage of Medicare days plus total Medicaid days as a percentage of total days. If that figure is greater than 15 percent, a hospital gets a 2-percent increase in DRG payments up to a maximum increase of 15 percent at 40 percent. It has been estimated that 1,000 hospitals would be covered including 400 large urban hospitals that would receive the largest payments. Special payments would be made for rural hospitals and hospitals in States with weak Medicaid programs but strong county poverty programs. The provision was designed to be budget-neutral—drawing funds from other hospitals to make the adjustments.

Congressional staff estimated the adjustment to result in a shift of $800 million.

*HCFA regulations.*—In response to a Federal court order, HCFA published on December 31, 1985, a definition of disproportionate share hospitals.[34] The definition includes two types of hospitals: (1) Hospitals that serve a significantly disproportionate share of low-income patients; and (2) hospitals that serve a significantly disproportionate share of Medicare part A beneficiaries. To identify hospitals with a DS of low-income patients, HCFA has used a definition based on the ratio of hospital inpatient days for Medicare beneficiaries qualifying for supplemental security income payments divided by total Medicare hospital inpatient days. Those hospitals whose ratio was greater than 39.55 percent qualify. Out of 5,788 hospitals analyzed, HCFA identified 89 disproportionate share hospitals. HCFA found 18 hospitals with a DS of Medicare patients out of a pool of 5,443 hospitals. Those 18 had a ratio of Medicare days to total days in excess of 91.01 percent. However, HCFA also indicated that it was still not going to provide the adjustments, asserting that further analysis was still necessary.

### *(e) Anti-dumping penalties*

The reconciliation bill also included a provision to prevent hospitals from dumping costly or uninsured patients. The conference agreement specified that hospitals participating in Medicare would be prohibited from transferring any patient with an emergency medical condition or in active labor before that individual is stablized. A physician (or other qualified medical personnel if a physician is not available) must sign a certification that the benefits of a transfer outweigh the risks involved. Civil penalties would be imposed on hospitals and DHHS could terminate or suspend from Medicare any provider that knowingly ignores these provisions.

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[34] U.S. Dept. of Health and Human Services, Health Care Financing Administration, Medicare. Federal Register, v. 50, no. 251. December 31, 1985, p. 53398–53400.

### *(f) Direct medical education*

On May 16, 1985, Senators Dole, Durenberger, and Bentsen indroduced S. 1158 to reform the way Medicare pays for direct medical education costs. The bill would provide for a 1-year freeze on such payments; a limit on the number of years of physician training Medicare will fund thereafter (initial board eligibility or 5 years, whichever is less); exclusion of costs of training alien foreign medical graduate school graduates; and two studies to provide information for possible further changes, including a study of nursing and other health professions training programs and a study of the differences in Medicare costs between patients treated in teaching hospitals versus nonteaching hospitals. The Subcommittee on Health of the Senate Finance Committee held a hearing on this bill and related issues on June 3, 1985. A modified version of S. 1158 was incorporated into the Senate Finance Committee's deficit reduction package and the Senate's omnibus budget reconciliation bill (S. 1730).

Taking a different approach, Senator Quayle introduced S. 1210, and chaired a hearing of the Senate Labor and Human Resources Employment Subcommittee on graduate medical education on March 25, 1985. Under his proposal, Medicare would pay educational costs only when at least 75 percent of trainees in a graduate medical education program are graduates of an U.S. medical school approved by the Liaison Committee on Medical Education (LCME). His proposal would also allocate 70 percent of residency positions in each teaching hospital to primary care specialties and the balance to nonprimary care specialties.

In the House, Representative Waxman introduced H.R. 2699 on June 6, 1985. This bill addressed both direct and indirect graduate medical reimbursement. It would standardize nationally the direct graduate medical education (GME) amount to be paid per resident and would limit increases in direct GME payments to the annual increases in the consumer price index. The standardized amounts would be weighted to encourage training of a higher proportion of primary care physicians. Primary care residencies would be worth more to hospitals than nonprimary care residencies. Unlike the Senate bills, the Waxman proposal would not eliminate or limit payment for foreign medical graduates but would require them to pass both parts of the Foreign Medical Graduate Examination in Medical Sciences in order to be counted as residents for Medicare payment purposes. H.R. 2699 would also phase down the indirect cost adjustment from the current 11.58 percent to 10 percent in fiscal year 1986, 9 percent in fiscal year 1987, and 8 percent in fiscal year 1988. To discourage expanding programs, the amount of extra payment would be reduced as the hospital's ratio of residents to beds increased.

Both the House and Senate incorporated medical education changes in their deficit reduction packages. The House Ways and Means Committee (H.R. 3128) provided that for cost reporting periods beginning during the 1-year period starting on July 1, 1986, the Secretary of DHHS would be prohibited from implementing the regulations freezing the reimbursement rates for graduate medical education. For indirect payments, the House Ways and Means bill reduced the existing adjustment of 11.59 percent to 8.1 percent for fiscal year 1986 and fiscal year 1987 on a curvilinear basis. The adjustment would be raised to 8.7 percent in fiscal year 1988 (upon expiration of the disproportionate share adjustment).

*Geriatric fellowships exemption.*—The Senate bill (S. 1730) provided that no increase in direct medical education costs be allowed in fiscal year 1986. Beginning in fiscal year 1987, Medicare would begin to phase out payments for education of graduates of nonaccredited medical schools. Payments would also be discontinued for the training of residents beyond board eligibility or the fifth year of a residency program, whichever occurs first. However, an exception was created for geriatric fellowships. Senator Heinz pressed for this exception because of his concern that the 3-year/5-year limit would cut off support for the development of geriatric medical expertise—the one type of training that is immediately and directly relevant to the Medicare population. Senator Heinz's amendment would exempt geriatric fellowships which meet certain criteria from the payment limits. Under S. 1730, payment limits were also placed on reimbursement for foreign medical graduates.

Under the Senate bill, the existing adjustment for indirect payments would be reduced to from 11.59 percent to 7.7 percent for fiscal years 1986 and 1987, and 8.7 percent for fiscal years 1988 and beyond, on a variable basis.

Under the House-Senate conference agreement, payments for direct graduate medical education costs would be increased on March 1, 1986, by 1 percent above fiscal year 1985 amounts; payments would be made for all residents and interns on staff as of that date. In fiscal year 1987 and fiscal year 1988, direct GME payments would rise by an amount equal to the increase in the Consumer Price Index for urban areas (CPU/U). With the exception of certain geriatric fellowships, payments for future GME students would be limited to the period leading to first board eligibility plus 1 year with an outer limit of 5 years. Any foreign medical graduate who passes both parts of the Foreign Medical Graduate Examination in the Medical Sciences would be eligible for support.

The indirect GME adjustment would be reduced from 11.79 percent to approximately 8.1 percent and the current straight-line formula would be replaced with a curvilinear formula that would reduce the size of the add-on as a hospital hires more interns and residents. The indirect and direct payment changes would cut payments to teaching hospitals by nearly $2 billion in fiscal year 1986–88.

*HCFA regulations.*—On July 5, 1985, HCFA published final rules that limit Medicare's payments for direct medical education costs to Medicare's share of the lesser of the hospital's current direct costs for medical education activities or its costs in a base year. Under the Emergency Extension Act (Public Law 99-201), however, hospitals operate as if it was December 30, 1985, meaning that they continue to receive last year's GME payments.

Changes in Medicare payment policy for graduate medical education will have a significant effect on the policies of other payers. As

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[85] U.S. Dept. of Health and Human services, Health Care Financing Administration, Medicare. Federal Register, v. 50, no. 129. July 5, 1985, p. 27722.

John Iglehart has observed "Changes at the Federal level will have a ripple effect that will compel States, teaching hospitals, medical schools and private accrediting bodies to evaluate their own operations.[36] They are also going to affect more than just graduate medical education—they could also have an adverse effect on hospitals' willingness to take charity care. Historically, at least, teaching hospitals have carried a heavy load of charity patients. "As price competition takes hold, it will grow more difficult for teaching hospitals to incorporate the costs of education within the costs of patient care and to cross-subsidize the costs of uncompensated care, regional standby services and clinical research.[37]

### *(g) Medicare Capital Payments*

Senators Durenberger and Quayle introduced S. 1559, the "Medicare Capital Payment Reform Act of 1985" on July 16, 1985. This bill would amend section 1886 of the Social Security Act to incorporate payment of capital-related costs into the Medicare hospital prospective payment system. Capital-related payments would be determined by a flat percentage increase in the hospital's applicable national payment rate for Medicare discharges in each of the DRG's. Capital-related costs of hospitals excluded from PPS would continue to be reimbursed on the basis of incurred costs. The bill also provides for repeal of section 1122 of the Social Security Act (1122 requires each State to have a capital expenditure review agreement with the Secretary of HHS as a prerequisite for hospitals in that State to be reimbursed by Medicare for capital-related costs).

Another proposal affecting capital payments is S. 1346/H.R. 1801 "the Medicare Solvency and Health Care Financing Reform Act of 1985," introduced by Senator Kennedy and Representative Gephardt. This is a comprehensive health care reform bill which seeks to provide for an all-payers prospective payment system. The capital-related provision of this bill would amend section 1886 of the Social Security Act to establish prospective payment rates for making payments to hospitals for capital-related costs under Medicare's PPS. Hospitals included in the Medicare PPS would be paid a DRG-specific, regionally adjusted, prospective amount per discharge for capital-related costs in addition to any DRG payments for operating costs. Hospitals excluded from PPS would continue to be reimbursed for capital-related costs on an incurred cost basis. In addition, these provisions would prohibit payments to hospitals for a return on equity capital.

Under reconciliation, Congress worked out a compromise on Medicare's policy for reimbursing return on equity for for-profit hospitals. Payments to proprietary hospitals for return on equity would be phased out over the next 4 years beginning October 1, 1986. In the first year, payments would be cut to 75 percent; 50 percent in the second year; 25 percent in the third year; and zero in the fourth. The provision would also prohibit DHHS from including any return on equity payments in a prospective payment rate for capital.

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[36] Iglehart, John K., Federal Support of Graduate Medical Education. New England Journal of Medicine. v. 312, no. 15, April 11, 1985, p. 1000.

[37] Ibid., p. 1001.

The Finance Committee's Subcommittee on Health held the only major congressional hearing on reform of Medicare capital payments on November 8, 1985. The only witness was Robert Helms, Acting Assistant Secretary for Planning and Evaluation of DHHS.

### *(3) Provisions Affecting Beneficiaries*

#### *(a) Part B premium*

The part B premium would be held at 25 percent of program costs through 1988 (1 year beyond current law).

#### *(b) Part A deductible*

HHS must publish the next year's deductible amount by September 15 rather than by the current October 1 deadline.

#### *(c) Hospice care*

Medicare's hospice benefit, scheduled to expire in 1986, would be made permanent and all payment levels would be increased by $10 per day.

#### *(d) Working aged*

Medicare's working aged policy would be extended to beneficiaries over age 69 if they or their spouses work and elect the employer-based health insurance plan.

#### *(e) Part B appeal rights*

Beneficiaries would be able to obtain an administrative law judge hearing for part B claims in dispute if the amount is $500 or more and a judicial review if the amount is $1,000 or more. Beneficiaries also could be represented by a hospital or physician.

#### *(f) Benefit expansions*

Coverage of occupational therapy services would be added under part B; vision care services provided by an optometrist would be added under part B.

### *(4) Provisions Affecting Other Providers and PRO's*

#### *(a) Assistants at surgery*

Medicare would no longer pay for assistants at surgery in a cataract operation unless the appropriate peer review organization or Medicare carrier approves the use prior to surgery.

#### *(b) Durable medical equipment*

Payments for durable medical equipment would be frozen for 1 year except for rental equipment and oxygen, which would receive a 1-percent increase. Payment for rental equipment must be on a mandatory assignment basis. Payments after fiscal year 1986 would be increased by the CPI/U.

### *(c) Clinical laboratory services*

An increase in payments for clinical laboratory services would not occur until October 1, 1986, and would be based on the CPI/U over the previous 15-month period. HHS would be required to set a ceiling on payments of 115 percent of the median for fiscal year 1987, 110 percent for fiscal year 1988, and national fee schedules for fiscal year 1989 and beyond. As of January 1, 1987, payments to laboratories in physicians' offices would be the same as independent laboratories, including mandatory assignment.

### *(d) Peer review organizations*

PRO review of HMO's would begin on January 1, 1987. Payments to PRO's would not be permitted to drop below the fiscal year 1986 base in any future year. Accepting a modification of Senator Heinz's bill, S. 1623, PRO's would be authorized to deny payment for substandard care. PRO's would also become the enforcement agent for a new second surgical opinion program. Incorporating a modified version of Senator Heinz's bill, S. 1325, the reconciliation bill would authorize PRO's to use mandatory second opinions as a tool with which to help beneficiaries prevent unnecessary surgery. PRO's would target those surgical procedures which may be overutilized in their areas and would review their medical necessity before the patient undergoes the operation. If the PRO questions whether the surgery is medically necessary, it would have the authority to require the patient to get a second opinion before Medicare would cover the surgery. In these cases, Medicare would cover the full cost of the second opinion, and the patient would be free to choose to undergo the surgery at Medicare's expense, but the patient would have the benefit of receiving more information with which to make a wise decision about undergoing surgery.

### *(e) Physician payments*

In the first session of the 99th Congress, there were two major hearings on physician payment reform—the House Committee on Energy and Commerce, Subcommittee on Environment held a hearing on physician payments under Medicare on April 26, 1985; and the Senate Finance Committee, Subcommittee on Health, held a hearing on reform of Medicare payments to physicians on December 6, 1985.

Most of the activity on physician payment took place in the context of the reconciliation process. In H.R. 3128, the House Ways and Means Committee provided that any physician who signed a participation agreement effective for the year beginning October 1, 1985, would receive an increase in Medicare payments. For any physician who did not sign an agreement, the freeze on Medicare payments would be extended for 12 months, beginning October 1, 1985. The prohibition on increases in actual charges for all nonparticipating physicians would be extended for 12 months, beginning October 1, 1985. Both participating and nonparticipating physicians would be given an increase in Medicare payments on October 1, 1986; however, increases for nonparticipating physicians would be lagged 1 year behind those of participating physicians. Various incentives for participating were also included.

H.R. 3128 also provided for the expansion of PROPAC to include a new subcommittee which would make recommendations concerning physician payments. Finally, the bill required the Secretary of DHHS, with the advice of PROPAC, to develop a relative value scale, based on resource costs.

The Energy and Commerce Committee bill (H.R. 3101) would extend the physician fee freeze for an additional 12 months for most nonparticipating physicians. Commerce agreed to increase fees for nonparticipating physicians who accepted assignment in 100 percent of their Medicare cases but that increase would be half as large as that for participating physicians (approximately 2 percent). The bill also provided incentives to encourage physicians to become participating physicians.

H.R. 3101 provided for the establishment of an independent 11-member Commission appointed by the Director of OTA to carry out the same tasks regarding physician payment as provided for in the Ways and Means version.

Under the Senate Finance Committee deficit reduction package (S. 1730), the provisions were comparable to the Ways and Means Committee's version with a few modifications relating to the calculation of actual charges for participating physicians. There was no provision for a commission study of physician payments as provided for under the House-passed bill.

*Conference agreement.*—Under the conference committee agreement, physicians who agree to be participating physicians in 1986 (before a January 31 deadline) would receive an increase in the fees equal to a rise in the Medicare economic index plus 1 percent (approximately 4.1 percent in total) on February 1, 1986. Physicians who do not join the participating physician program would remain under a fee freeze until January 1, 1987, when they would receive a 3.1-percent increase. Updates in physicians fees in future years would be made on January 1.

In addition, a new 11 member commission on physician payment reform would be created and called the Physician Payment Review Commission. The commission would make recommendations by February 1 of each year on the appropriate adjustments to be made in Medicare physician payments and the development of a relative value scale.

### *(5) Proposals Rejected by Congress*

The Congress rejected the administration proposals to impose a 1-month delay in eligibility for Medicare, index the part B deductible, increase the part B premium to cover 35 percent of program costs, and implement a Medicare voucher system.

#### *(a) The SMI (part B) premium*

As noted earlier, the administration proposed that the part B premium be increased to cover 35 percent of program costs. This move was rejected by Congress. On September 30, 1985, HCFA announced that the monthly part B premium would remain at the 1985 level of $15.50 for 1986. However, for 1987, the monthly premium is likely to increase to $18.60; in 1988, it is estimated to climb to $19.40. Thus, beneficiaries will be expected to pay an increasing amount for their part B coverage.

### *(b) Taxing the value of a portion of SMI benefits*

As part of its deficit reduction package, the Subcommittee on Health of the House Ways and Means Committee considered and passed a proposal to impose a tax on the value of the SMI premium for higher income beneficiaries. Under this proposal, the monthly part B premium would be a fixed amount per month for calendar years 1986, 1987, and 1988. A tax would be imposed on the excess of adjusted gross income over $20,000 for individuals, $40,000 for couples, and capped at $60,000 for individuals, and $120,000 for couples, for all part B enrollees. The provision was designed to finance 25 percent of program costs for those 3 years.

This provision was rejected by the full Ways and Means Committee and did not surface again in 1985. This, or other proposals to means test Medicare benefits or Medicare premiums, are likely to surface again in 1986 as Congress and the administration seek options for curbing the growth of Medicare outlays.

Critics of such proposals argue that they undermine the social insurance basis of Medicare. If Medicare is subjected to means testing, then it could be viewed as a social welfare program, vulnerable to the same budget cuts and program restrictions that have been implemented in the Medicaid and welfare programs. Arguments in favor of means testing or implementing an income-related premium include: (1) The payroll tax for the part A, HI trust fund has been earmarked only since 1966. Therefore, the payment of benefits to the aged and disabled has far outstripped the actual value of their contributions; (2) part B, SMI, has even less claim to being social insurance because it receives no payroll tax contributions, and any elderly person can participate regardless of Social Security eligibility; (3) given the threatened budget cuts in Medicare, it may be better to make changes that will lessen the impact of the cuts on low-income beneficiaries than to be forced to accept proposals that will jeopardize their access and greatly increase their burden of out-of-pocket costs.[38]

### (D) GRAMM-RUDMAN-HOLLINGS

With the passage of the Gramm-Rudman-Hollings amendment to the bill raising the national debt limit (H.J. Res. 372, Public Law 99-177), Medicare outlays will be subject to additional cuts in fiscal year 1986 and thereafter. Under a sequester order, the reductions in the Medicare Program are to be achieved through reductions in payment amounts for covered services. No changes in coinsurance or deductibles are to be made, and cuts are technically not to be made to basic benefits. Under the sequester order, however, each payment amount made under the Medicare Program would be reduced by a specified percentage, which would generally be 1 percent for fiscal year 1986 and 2 percent for each subsequent year in which there is a sequestration.[39]

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[38] U.S. Congressional Budget Office, Reducing the Deficit: Spending and Revenue Options. A Report to the Senate and House Committees on the Budget. Part II. Washington, U.S. Govt. Print. Off. Feb., 1985.

In any year for which there is a sequestration, the reduction in Medicare would be made from whatever level of payment would otherwise be provided under Medicare law and regulations. If hospital prospective payments were scheduled to increase by 4 percent, then a 2-percent reduction would permit some increase to remain. On the other hand, if no hospital prospective payment increase were scheduled pursuant to Medicare law, then the sequestration reduction would reduce payments below the previous year's rates.

The effects of Gramm-Rudman-Hollings on Medicare could be substantial, but at this writing, it is unclear as to whether the sequestration procedures will work as outlined. While the cuts made under sequester orders are not directly aimed at beneficiaries, there is little doubt that beneficiaries will feel their effects as providers seek to recover from beneficiaries any losses they incur from reduced Medicare payments. Moreover, hospitals—which are going to absorb the bulk of the cuts—may respond by reducing access to care for Medicare beneficiaries as well as the quality of service to those beneficiaries. Without Gramm-Rudman, Medicare payments to hospitals are not expected to rise much above current levels, despite expected inflation of 3 to 5 percent in each of the next 5 years. With it, they may actually experience a cut below current levels.

The effects on hospitals will not be immediate in most cases. The industry as a whole experienced record profits in 1985. Nevertheless, in tandem with the phase-in of national DRG payment rates, Gramm-Rudman cuts to Medicare could have damaging effects on many institutions, especially those already operating close to the margins. The ripple effects on other parts of the health care industry are also likely to be substantial. For example, as hospitals adjust to lower DRG payments from Medicare, they are likely to purchase less medical equipment, thus reducing the market for the health equipment manufacturers. This may also lead to reductions in hospital purchases of new technologies.

### (E) MEDICARE PART A DEDUCTIBLE LEGISLATION

Under Medicare, beneficiaries are not covered for the first day of hospitalization for each spell of illness. They must also pay a copayment for the 61st through 90th day of hospital care and a copayment for the 21st through 100th day of stay in a skilled nursing facility. On September 30, the Secretary of DHHS announced that the part A hospital deductible would increase from $400 to $492, effective January 1, 1986. This is a 23-percent increase in 1 year and close to a 141-percent jump since 1981. It is also a revised amount, the administration having announced earlier in the year that the deductible would rise to only $476.

According to HCFA, the impact of this increase will be felt by approximately 8 million beneficiaries using hospital and/or skilled nursing services in 1986, and will cost beneficiaries $1.1 billion.[39] The increase will hit hardest on America's low-income elderly.

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[39] U.S. Congress. Conference Committees, 1985. Conference Report to Accompany H.J. Res. 372. 99th Congress, 1st Session. Washington, U.S. Govt. Print. Off., 1985.

Under current law, HCFA must use an outmoded methodology for determining the annual increase in the inpatient deductible: It is made by calculating the average cost incurred by a patient for 1 day's stay in a hospital. Under the prospective payment system, however, reimbursement is based on resources needed to care for a patient with a specified diagnosis or DRG. As DRGs are fully phased in, the length of stay will continue to drop, but the intensity of services delivered per day is becoming greater. Thus costs per day are rising even while the escalation in total hospital costs under Medicare has slowed.

*Bills introduced.*—Several Members of Congress introduced bills to change the calculation of the HI deductible and the other copayments affected by it. On October 2, 1985, Senator Heinz introduced S. 1729, the Medicare Beneficiary Fairness Act; Senator Kennedy and Representative Stark introduced companion legislation (S. 1613; H.R. 3210) which included a similar provision.

Under these bills, the inpatient deductible is determined on the basis of the annual increase in the hospital DRG propsective payment rates (in fiscal year 1986, likely to be about 1 percent), instead of on the average cost of care for 1 day's hospitalization, as it is currently calculated. In addition, the copayment for extended nursing home care (scheduled to rise from $50 to $61.50), would be linked to the DRG payment rate, thus lowering it to a more affordable rate.

Bills using other approaches to holding down the deductible (H.R. 3630, H.R. 3631, H.R. 3635) were introduced by a number of Members of the House. No action was taken on these bills in the first session of the 99th Congress.

*Senate action.*—On December 9, the Senate—by a vote of 45 to 41 on a procedural motion—blocked a Heinz amendment to the continuing resolution (H.J. Res. 465) to cap the deductible at $476, the amount originally announced by DHHS. Senators Heinz and Kennedy then offered a sense of the Senate resolution, which was adopted, that directs the Finance Committee to report legislation no later than April 15, 1986, to reform the calculation of the annual increase of the deductible so that is is more consistent with the annual increases in Medicare payments to hospitals. The resolution also provides that any reforms reported back by the Finance Committee would be retroactive to January 1, 1986.

Efforts were also made to address this issue through the budget reconciliation process. Although the conferees for H.R. 3128, the Consolidated Omnibus Budget Resolution Act, agreed to change the date of the annual notification of the scheduled increase to allow beneficiaries more time to adjust to the new rates, no other changes were agreed to, largely because of the anticipated cost of any reduction in the scheduled increase. This could become an issue again in 1986.

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[40] U.S. Dept. of Health and Human Services, Health Care Financing Administration, Medicare. Federal Register, v. 50, no. 198, Sept. 30, 1985. p. 39940.

### (F) MEDICARE AND MEDICAID PATIENT PROTECTION ACT

In response to the problems addressed at the Senate Special Committee on Aging's hearings, Chairman Heinz and Senator Glenn of the Aging Committee introduced S. 2744, the Medicare and Medicaid Patient Protection Act of 1984, which would have significantly expanded the Federal Government's authority—and the States' authority—to exclude health care practitioners from Medicare and Medicaid. This bill would also have established a minimum exclusionary period of 5 years, instituted better coordination between Federal agencies and State sanctioning boards, imposed reporting requirements on State licensing authorities, and strengthened civil and criminal penalties. A similar bill was introduced in the House, but neither passed before the end of the 98th Congress. Both bills underwent fine-tuning and were reintroduced in the first session of the 99th Congress as S. 837 and H.R. 1868. In addition, Senator Roth, by request, introduced S. 1323, a modified version of the other bills which adds additional sanctioning authority recommended by DHHS. H.R. 1868 was passed by the House on June 4, 1985. All three bills were taken up in a Senate Finance Committee hearing on July 12, 1985, and it is expected that the Senate version will pass in 1986.

### (G) QUALITY OF CARE LEGISLATION AND REGULATIONS

#### *(1) Proposed Quality of Care Bill*

The staff of the Senate Special Committee on Aging has set forth a series of recommendations to improve quality of care under PPS. These will be incorporated into legislation to be introduced in the second session of the 99th Congress by Senators Heinz and Glenn and Representative Stark.

*(a) Protecting quality of care in acute care settings*

1. Congress should promptly enact a set of adjustments to the DRG classification system to better reflect differences in severity of illness between patients in the same DRG category.
2. The Secretary should immediately remind Medicare certified hospitals of the illegality, under section 504 of the Rehabilitation Act of 1973 (as amended), of discriminating against patients on the basis of their disabilities, and initiate enforcement action where appropriate through the DHHS Office of Civil Rights.
3. The Secretary should revise the PRO scope of work to require comprehensive quality assurance monitoring and enforcement activities.
4. The Congress should pass S. 1623, incorporated in the conference report for H.R. 3128, the Consolidated Omnibus Budget Reconciliation Act, which would for the first time authorize PRO's to deny reimbursement for substandard care provided to beneficiaries under Medicare, while helping to guarantee the financial viability of the PRO's.
5. Congress should authorize and appropriate funding levels for the second round of PRO contracts which will reflect the urgent need for at least as high a volume of quality review as utilization

review, and which will reflect, as well, the greater cost per quality review conducted by PRO's.

6. Congress should require within each State the creation of a Consumer Advisory Board (CAB) to conduct oversight of the PRO's, provide input into the award and evaluation of PRO contracts, and receive input from Medicare beneficiaries and other interested parties. The board should be coordinated with or otherwise provide for a patient advocacy system to assist the acutely ill elderly and their families. Each board would be required to make annual reports to the Governor and to DHHS. DHHS would be required to utilize CAB input in its decision to award PRO contracts. The CAB should consist of the long-term care ombudsman, and protection and advocacy officials in each State, and organizations representing the elderly and disabled.

### *(b) Improving hospital discharge planning*

1. Expand existing law, which provides for "administratively necessary days" payments to hospitals for a patient's extended hospital stay when no nursing home bed is available, and to provide for such payments when no *appropriate* post-hospital care placement—in terms of the level of skilled care and quality—can be found at the time of proposed discharge from the hospital.

2. Congress should upgrade Federal rules for hospital discharge planning to include: (1) Pre-discharge consultation between all professionals giving care to the patient; and (2) informing beneficiaries, prior to discharge, of (a) their entitlement to Medicare and Medicaid post-hospital benefits, (b) rights of appeal, (c) the identity of the local long-term care ombudsmen, and (d) the nearest location of deficiency reports on local providers under consideration for placement of the patient.

3. DHHS should voluntarily suspend plans to deregulate hospital quality assurance and discharge planning until it reports to Congress on the effects of PPS.

### *(c) Extend quality of care protections to post-acute care settings*

1. PRO's responsibilities for quality assurance should be extended so that they are required to track a pre-specified percentage of patients discharged from the hospital through the continuum of nursing home, home health, and other community-based services.

2. Authorize and fund PRO's to do expanded quality of care reviews (1) of nursing homes and home health care agencies to ensure that quality care is planned and delivered after the patient's discharge from a PPS hospital; (2) increased PRO reviews of readmissions to those occurring within a period of 30 days.

3. Congress should authorize the creation of an interagency panel, consisting of Representatives of Congress, the Health Care Financing Administration, the Prospective Payment Assessment Commission, the American Medical Peer Review Association, the Department of Health and Human Services' Office of the Inspector General, beneficiaries, and health care practitioner and provider representatives. This panel would make a concerted effort to seek out quality problems, in hospital as well as post-hospital settings, and would develop criteria for a uniform quality of care review

system. This panel would report to Congress as soon as practicable on its findings and recommendations.

4. Eliminate current "level of care distinctions governing nursing home reimbursement under Medicaid, concurrently with mandatory State phase-in of a reimbursement system based upon patients' individual needs and characteristics.

5. Expand advocacy assistance for older Americans: (1) Authorize long-term care ombudsmen to have access to hospitalized Medicare patients, interview hospital personnel and, with patient's permission, examine complete hospital record; mandate a State ombudsman representative on PRO advisory or corporate boards; (2) fund training of ombudsmen in (a) Medicare PPS, and (b) all Medicare part A appeals; (3) establish funding formula for ombudsman programs based upon workload; and (4) provide ombudsmen with immunity from suits for good faith performance of duties.

6. Restructure Medicare's eligibility determination and appeals process: (1) Adopt a uniform needs assessment tool for post-hospital benefits, based upon patients' functional abilities, and relieve providers of burdensome "UB-82" forms; (2) institute PRO pre-discharge eligibility determination for Medicare and Medicaid benefits, with an opportunity for patients to initiate appeal prior to discharge; (3) eliminate the 3-day prior hospitalization requirement for Medicare SNF benefit; (4) mandate an appeal opportunity for beneficiaries when a provider fails to submit a claim; (5) create penalties for fiscal intermediaries or PRO's that improperly deny benefits; and (6) retain waiver of liability protections for providers.

#### *(d) Protecting quality in nursing homes*

1. Improve protections for nursing home residents. Congress should enact a minimum set of sanction authorities, which would: (1) Empower State enforcement officials to impose receivership on substandard nursing homes; (2) provide Federal financial participation for care of residents during the period of a receivership; (3) strengthen patients' rights; (4) authorize States to impose civil penalties and suspend reimbursement to noncompliant providers; (5) expedite sanction and provider appeal at chronically substandard nursing homes; (6) prohibit discrimination in admission or treatment of patients based on source of payment; (7) empower residents to enforce provider agreements with private right of action; (8) impose a moratorium on HCFA's scheduled January 1986 implementation of a new nursing home inspection survey system (PACS), for public review and comments.

### *(2) Other Legislation*

There were a variety of other bills introduced in the first session of the 99th Congress to respond to the growing quality of care problems under PPS. Representative Roybal, Chairman of the House Select Committee on Aging, introduced H.R. 1970, the Medicare Quality Assurance Reform Act, on April 3, 1985. This was followed with the introduction by Senator Proxmire and Representative Snowe of a resolution (S. Con. Res. 58, and H. Con. Res. 221) calling for the Secretary of DHHS to convene a working group to draft a Medicare patient bill of rights. On April 17, the Subcommittee on

Health of the Senate Finance Committee held a hearing on the progress of implementing the PRO program. On July 30, 1985, the Subcommittee on Human Resources of the House Committee on Education and Labor held a hearing on the effects of Medicare's DRG prospective payment system on Older Americans Act programs. Another set of hearings on the impact of PPS was held by the House Budget Committee's Task Force on Health on September 30, October 7, and October 21, 1985. Finally, Representative Hammerschmidt introduced on November 19 two bills relating to quality of care issues: H.R. 3781, which requires that severity of illness be taken into account in the DRG's and H.R. 3782, providing for reforms in the PRO reconsideration and appeals process.

### *(3) Regulatory Activity*

Long overdue, HCFA published final rules for the peer review organizations on April 17, 1985. The rules relate to four aspects of PRO activity: (1) The conduct of review and the Medicaid relationship with PRO's; (2) the reconsideration and appeals process; (3) the sanctioning of health care providers and facilities; and (4) acquisition, protection and disclosure of PRO information. HCFA also submitted a report to Congress, mandated by section 1161 of the Social Security Act, on the administration, impact and cost of the PRO program.

At the end of 1985, HCFA had indicated its willingness to move forward on a number of the recommendations made by the Senate Special Committee on Aging to improve quality under PPS. First, in its proposed scope of work for the second round of PRO contracts, there was a much heavier focus on protecting quality of Medicare inpatient services than the previous scope of work. While the new draft scope of work, released November 4, 1985, did not offer new funds for review of outpatient services, ambulatory surgery programs, HMO's or long-term care services, it did propose expanded monitoring of hospital readmissions, review of elective admission involving 1- or 2-day stays, the use of generic quality screens, and a new quality objective aimed at reducing premature discharges. The proposal also improved on the existing scope of work by giving more explicit guidance on denying reimbursement to hospitals for cases found to represent poor quality care. In addition, the proposed scope of work requested assistance from PRO's in developing an outreach program to correct misinformation beneficiaries receive regarding PRO functions, the appeals process, and other patient rights issues.

### (H) HMO LEGISLATION

*Reconciliation provisions.*—In order to address emerging problems with HMO's, several provisions have been included in the reconciliation package for fiscal year 1986. One provision helps to clarify whether it is the Medicare Program or the HMO that is financially responsible for patients hospitalized on the effective date of enrollment or disenrollment. A second provision shortens the waiting period before disenrollment becomes effective. A third provision requires all TEFRA HMO/CMP's to submit their brochures, application forms, and promotional and informational material to

HCFA for premarket approval. Finally, another provision requires the Secretary of DHHS to implement PRO review of part A and part B services furnished by TEFRA HMO's and CMP's.

*Federal support for HMO's.*—Because 1984-85 was a record year in terms of HMO enrollment, a question has arisen as to whether continued Federal statutory suport for HMO's is necessary or wise. The HMO industry is divided over the answer to this question: Some HMO's feel that this support is still warranted while others believe that the support has now become a constraint which inhibits their ability to compete. The administration favors repealing the current equal contribution requirement that employers contribute no less to an HMO plan than they do to a traditional third-party insurer and the dual choice requirement that certain employers offer their employees an HMO. These changes are proposed on the ground that HMO's have grown sufficiently in number and in market strength so that they no longer need favorable treatment; instead, laws protecting and promoting HMO's should be repealed now that they have served their purpose.

On September 13, 1985, Senator Wallop introduced, at the administration's request, S. 1642, to repeal provisions authorizing assistance for feasibility surveys, planning, initial development, and operation of HMO's. The bill also would repeal provisions which currently authorize loans and loan guarantees for the acquisition and construction of ambulatory health car facilities. Most importantly, the bill would repeal current requirements on certain employers to include a HMO as an option in the health care benefit package they offer to employees.

Congress agreed that some of the Federal HMO laws are no longer necessary: On June 18, 1985, the House passed H.R. 2417, the "Health Maintenance Organization Act of 1985," to revise and extend the existing authority for another 3 years. While that bill does not eliminate the requirement that employers make HMO's available, it does repeal provisions authorizing assistance for feasibility surveys, planning and initial development, and construction of ambulatory care facilities. It also limits the availability of initial operating loans to entities with existing loan eligibility, and it repeals the requirements for HSA review, periodic demonstration of compliance, and certain financial reports. Senators Hatch and Kennedy have introduced the Senate companion bill, S. 1762, which is still awaiting action.

### 4. PROGNOSIS

Medicare emerged out of the fiscal year 1986 budget battles in far better shape than most would have predicted early in the year. The administration's original budget proposed close to $20 billion in cuts over 3 years. The reconciliation bill (H.R. 3128) would produce about $11 billion in savings over 3 years. Beneficiaries were largely spared as Congress sought to achieve most of the savings from cuts to providers.

However, Congress made little or no progress in moving toward comprehensive reforms of the Medicare Program, leaving part B of the program in particular, dangerously vulnerable to new budget cutting efforts in fiscal year 1987. While Medicare is shielded from the full force of Gramm-Rudman-Hollings, it nevertheless will play a very major role in the 1987 sequester, should it occur. Whichever budget reduction process is pursued, Medicare and its 30 million beneficiaries, are likely to be participants in a painful process of belt-tightening and program retrenchment.

Medicare is expected to purchase quality health care for its beneficiaries. The meaning of quality, however, is poorly defined. What is clear is that quality care represents more than the absence of avoidable death, unnecessary surgery, serious patient complications, or unnecessary hospital readmissions. These criteria represent the scope of current quality objectives defined by HCFA.

A balanced assessment of quality of care requires attention to both process and outcomes. Critical questions are what changes in processes of hospital care are taking place as a result of PPS and what is the relationship between these processes and patient outcomes. PPS will affect the quality of care in both positive and negative ways. Any comprehensive evaluation of the impact of PPS along these lines will be time consuming, but is very necessary. PRO's are currently faced with severe funding constraints, and, in some instances cost containment priorities, that interfere with their ability to protect beneficiaries against the most extreme negative effects of PPS.

Assessment of the impact of PPS must consider the effects on both the quality of hospital care as well as the quality of care received in other settings. PPS will have its most immediate impact in the hospital, but as access to care in long-term care settings changes, the impact of PPS on quality will expand to include the entire medical system.

This country has little experience with measuring the effects of PPS on quality. A thorough assessment of PPS can be made only after a substantial time period has elapsed. The time to establish appropriate data collection strategies and monitoring systems so that information is available for such assessments is past due.

There are several obstacles to achieving an accurate and balanced view of the impact of PPS (e.g., limitations of existing data bases, the presence of multiple, simultaneous changes in the health care system, etc.). Nevertheless, significant efforts need to be directed toward measuring the extent to which PPS has met its objective.

The Medicare Program faces difficult times ahead. With budget cuts ratcheting down reimbursement rates for providers, pressures will increase to deliver care at the lowest cost possible. In the absence of careful and constant monitoring, providers may reduce care at the same time that they are reducing costs—at the expense of America's senior citizens. The success of PPS rides on the willingness of patients, providers, and regulators to get the most out of an increasingly lean system. In 1985, the Congress helped to spotlight the many problems developing under PPS with quality and access to care; in 1986, it is hoped that the responses to these problems will be immediate and appropriate.

## B. EMPLOYER-PROVIDED HEALTH BENEFITS

### 1. BACKGROUND

### (A) PRIVATE EMPLOYER PLANS

Employer- or union-sponsored post-retirement health benefits are group health insurance plans which provide coverage for retirees not yet eligible for Medicare, and which supplement Medicare benefits for retirees aged 65 and above. Medicare is the fundamental health benefit for retirees, covering over 26 million older persons—almost every American over the age of 65. Medicare does not by itself meet all of the critical needs of retirees over 65. Also, Medicare coverage is not available to retirees younger than age 65.

The most important benefit of participation in these group plans is the opportunity to continue participating after retirement rather than being forced to purchase an individual health insurance policy. The cost of purchasing an individual policy before age 65 may be prohibitive, and retirees may have difficulty finding an insurance company which is willing to offer them coverage if they have some pre-existing medical condition which could be costly to the insurer. Through lower administrative costs and higher employer contributions, group insurance typically offers beneficiaries a higher range of benefits at a lower cost than persons with non-group insurance can obtain.

Presently, continuation in group plans by retirees is rare. A report issued by the House Select Committee on Aging on June 27, 1984, estimated that one out of every six elderly Americans is receiving a portion of their health coverage from an employer or union. When middle-aged retirees are included, the estimate is that 5.5 million retirees and more than 3.8 million spouses are covered by private employer- or union-sponsored health plans.

It is primarily large employers who offer this continuation coverage for retirees. According to survey data collected by the Washington Business Group on Health, approximately 8 out of 10 large employers provide post-retirement health coverage.

Those employers who provide coverage for retired employees and their families in a group health plan generally provide full coverage in the company's plan until age 65. At that point, most corporations provide comprehensive health coverage related directly or indirectly to the benefits provided by Medicare, usually through a "carve-out" or a "Medicare supplement". The carve-out continues the retiree in the employees' group plan, but carves out benefits provided by Medicare to avoid duplicate coverage. In a variation on this approach, called "coordination of benefits", the plan pays what it would in the absence of Medicare, but the total payment is limited to 100 percent of the expense. Because this type of plan pays for services that Medicare does not pay for, its costs are affected by changes in Medicare benefits.

The Medicare supplement avoids this problem by specifying exactly the benefits that will be paid by the plan. In addition, the supplement can tailor benefits to the needs of the retiree. When the costs of the supplement can be more easily controlled, this approach requires the design and administration of a separate plan.

It also may result in a change in benefits for early retirees at age 65.

### (B) FEDERAL RETIREES PLAN

The Federal Employees Health Benefits (FEHB) Program is the world's largest employer-sponsored health plan, providing voluntary health insurance coverage for 10 million Federal employees, retirees, and their dependents at a total annual cost of approximately $5 billion. Federal retirees who satisfy certain requirements can continue their coverage as long as they pay the employee share of the premium.

Under the program, enrolled employees and retirees are offered a choice of different health plans through which they can elect coverage. Premiums for the various FEHB plans are paid through contributions from the Federal Government and from the enrollees. Under current law, the Government's share of the premium is equal to 60 percent of the average of the premium rated for the largest six plans (the Big Six), not to exceed 75 percent of the total premium for any individual FEHB plan. The enrolled employees and retirees pay the remainder of the premium cost, generally through deductions from paychecks or annuities.

## 2. Issues

### (A) RETIREE HEALTH BENEFITS

One aging issue which continues to be of crucial importance to private sector employers is the high cost of health benefits for their older workers and retirees. This issue is certainly not new, but recent Federal policy changes and financial accounting requirements have exaggerated the problem and made it more visible to employers. With the growth in retirees entitled to employer-provided health benefits, and the cost of health care continuing to rise there is heightened interest in providing a mechanism for ensuring that funds are available to pay for benefits in the future. A hearing before the Finance Subcommittee on Savings, Pensions, and Investment Policy on post-retirement health benefits, chaired by Senator Heinz on September 9, 1985, shed some light on this important issue.

#### *(1) Protection for beneficiaries*

Retirees are increasingly concerned that health benefits won't be provided if an employer goes out of business or simply decides for cost containment reasons to stop providing the benefit. This is certainly a legitimate concern because, traditionally, employers have not prefunded these benefits, preferring instead to handle these obligations on a pay-as-you-go basis. The Department of Labor has estimated that, for Fortune 500 companies, the unfunded liability for health benefits approaches $200 billion.

Retirees are finding protection in the Federal courts for their promised health benefits, and employers are increasingly being forced to recognize what had been, until recently, an informal obligation as a real legal and financial liability. Three recent court cases are particularly significant for the protection they offer to retirees' rights to receive health benefits. In *Eardman* v. *Bethlehem Steel Corp.* (607 F. Supp. 196 (1984)), Bethlehem Steel instituted cost containment features in a medical plan covering 16,000 non-union retirees. A U.S. district court, reviewing the terms of these plans, held that where the employer did not clearly retain the right to reduce or cancel retiree benefits, these benefits could not be reduced. Bethlehem appealed and, in a recent settlement, agreed to provide a permanent health program for the retirees combining the features of the original and modified medical plans.

In *Hansen* v. *White Farm Equipment Co.* (42 Bankruptcy Reporter 1005 (1984)), White Farm canceled retiree medical coverage when it filed for chapter 11 reorganization. A U.S. district court reversed a bankruptcy court decision and held that White Farm had to continue coverage because retirees had a vested right to their health benefits at retirement and the clause the employers had included in the plan to reserve the right to terminate benefits had not been sufficiently clear. White Farm has appealed.

A third case, *Musto* v. *American General Corp.* (615 F. Supp. 1483 (1985)), which is currently being appealed, goes further in its decision than the two cases above. Both *Bethlehem Steel* and *White Farm* implied that employers were free to modify benefits for retirees if they had clearly communicated before retirement that they reserved the right to do so. *Musto* prohibits modification by the employer regardless of what he has told his employees or retirees. Instead, the *Musto* case holds that employer health benefits vest upon retirement and are thereafter unchangeable regardless of the reservation clauses employers have incorporated in plan documents.

While some hail the *Musto* decision as a far-reaching development in the protection of retirees' rights, others question whether it has potential consequences which will do more harm than good. The Washington Business Group on Health (WBGH) has raised the concern that—by forbidding any change in retiree health plans—this decision not only prohibits employers from decreasing or terminating benefits for retirees, but also prohibits them from adopting plan modifications which help to contain escalating health care costs and increase the quality of care provided. The WBGH has warned that depriving employers of the ability to modify plans in any way will have the effect of "locking in" plans which are outmoded and wasteful, and will impose the entire burden of cost containment on future retirees.

### *(2) Pre-funding of plans*

As employers face increasing pressure to actually deliver the health benefits they have promised their retirees, employers are becoming more worried that they aren't financially prepared to bear these burdens and that they may need to consider some kind of pre-funding mechanism. This realization is occurring because of several factors. First, the growing cost of medical care, and employers' interest in containing these costs for employees, had led employers to recognize the vast amount of resources that will be needed to provide health benefits to retirees in the future. This is particularly a problem for employers involved in older industries which have a high ratio of retirees to active employees.

Employers are also afraid that the Federal Government, in its efforts to contain costs under Medicare, will make programmatic changes which result in shifting the responsibility for more of these costs to employers, particularly when the Government sees that employers are now being held liable by the courts for the delivery of health benefits they have promised.

A third factor pressuring employers is the growing recognition in the outside world that there are current liabilities of an employer which affect his net worth. A new accounting standard, recently adopted by the Financial Accounting Standards Board (FASB), requires employers to include—at least in a footnote on their annual balance sheet—a statement about how, or whether, they pre-fund their health benefit plans. FASB is expected to soon adopt another standard which will require employers to show their health benefit plan as a liability on their balance sheet. This should have the effect of focusing attention on such benefits and on how, or whether, employers plan to fund them. Being required to reveal this debt on a balance sheet or annual report has potentially far-reaching and worrisome implications for employers; it could make employers appear to be carrying a heavy financial debt and could put employers in a difficult position vis-a-vis applying for loans or engaging in mergers.

The three factors discussed above have led employers to reconsider the desirability of pre-funding retiree health benefit plans. Relatively few employers now pre-fund these benefits and, to date, there is no consensus as to whether pre-funding is desirable. Some employers feel that their obligation to provide these benefits is now legally unavoidable and, therefore, it is wise to pre-fund. Others have not yet accepted the inevitability of these obligations and continue to object to pre-funding.

Pre-funding will remain undesirable until tax incentives are available offering favorable treatment to employers for funds set aside to pay for future health benefits—similar to the favorable tax treatment which pension contributions receive. Yet, before the Federal Government will provide favorable tax treatment for these amounts, it must feel that some guarantees exist that these amounts will be used exclusively for retiree health benefits—in other words, that a clear liability exists necessitating pre-funding and the deferred taxation this entails.

### (B) THE MEDICALLY UNINSURED

In June 1985, the Senate Aging Committee held a hearing on the problems of the medically uninsured and found that there are 35 million Americans who lack health insurance. Some uninsured work in jobs that do not provide coverage; some lose their coverage when they become unemployed or experience a change in marital status through divorce or the death of their spouse. Some people are able to afford health insurance and are willing to pay for it but are unable to obtain it because they have a pre-existing illness or impairment that makes them high risks for insurers. This latter group of people is, in effect, uninsurable.

### (C) FEHB REFORM

Large FEHB premium increases in recent years, together with benefit reductions, have raised issues about the nature of the FEHB program, administration of the program, premium and benefit levels, and the amount of the Federal financial contribution to the program. In 1981, it was discovered that OPM projections for 1982 premium level increases (11 percent) were too low, due primarily to underestimates of inflation in health care costs and utilization of health benefits. In order to maintain plan benefits in 1982 at 1981 levels, premiums would had to have been increased by approximately 35 percent over 1981 levels. To avoid requiring such a large increase, OPM asked member plans to keep premiums as low as possible by adding such cost-sharing measures as increasing deductibles and coinsurance amounts, reducing coverage for certain benefits, and eliminating other benefits completely. With these benefit reductions, 1982 premiums increased approximately 17 percent over 1981 levels and 1983 premiums increased 18 percent over 1982 levels. Enrollees' share of the premiums increased by 22 percent in 1982 and another 15 percent in 1983.

The rise in health costs has slowed recently, lessening the sense of urgency behind proposals for FEHB reform: 1984 premiums increased 10 percent over 1983 levels, and 1985 premiums exceeded costs to such an extent that several of the plans offered rebates to their subscribers (see legislative activity below). OPM attributes this trend to the cost-sharing it introduced into FEHB plans in late 1981. However, other factors also played a role. For example, increases in the cost of health care have slowed: CPI medical care costs in 1982 exceeded 1981 levels by 11.6 percent, 1983 saw an increase of 8.7 percent, and the first two quarters of 1984 averaged a 6-percent increase. Also, many enrollees are switching from high- to low-option plans in order to reduce their premiums. In fiscal year 1982, more than 200,000 people left the high-option Blue Cross/Blue Shield plan alone. More data will be needed to document the extent of this behavior. Cost-sharing may decrease the Government's expenditure for FEHB but will not necessarily contain the rising costs of the program as a whole.

## 3. LEGISLATION

### (A) RETIREE HEALTH BENEFITS

Without some minimum standards guaranteeing that certain categories of retirees would be eligible for certain minimum benefits, determinable in real actuarial fashion, the Government has been unwilling to provide a tax mechanism for funding these benefits. In fact, as of January 1, 1986, one mechanism for prefunding has been removed from the tax code. Prior to the passage of the deficit reduction amendments of 1984, employers were able to establish VEBA's, or "voluntary employee benefit associations," into which they could set aside unlimited funds to provide for retiree health benefits. In order to receive a tax deduction for these funds, the employer only had to certify that the funds would, in fact, be used to pay for benefits.

DEFRA changed this by placing a cap on the amount of funds that could be set aside for tax purposes. Employers are now limited to setting aside no more than the total of their current expenditures for future uncertainties. This 75-percent limit, according to benefit consultants, is far below the amounts needed to account for increases in the size of the retiree population and the rapidly escalating costs of health care.

The Treasury Department took the position that, although the VEBA mechanism was not widely used, it had to be redrawn to avoid potential abuse. The Department stated that unlimited deductions were not appropriate for contributions which faced no requirements as to reporting or disclosure or limitations on total funding. This change has put the burden on employers to justify the need for a tax-favored funding mechanism for retiree health benefits. Senator Heinz chaired a Finance Subcommittee hearing to examine the issue of retiree health benefits, and to air the arguments for and against pre-funding with tax incentives, but there is no consensus at this point as to what the appropriate legislative response should be. A study by the Labor Department on the issue is due shortly, and Congress is still awaiting a study by the Treasury Department which is overdue.

### (B) MEDICALLY UNINSURED

#### *(1) Risk pools*

In response to the plight of the uninsurables, Senator Heinz introduced S. 1372, the "Health Insurance Availability Act of 1985." Congresswoman Kennelly introduced the House counterpart (H.R. 1770). Under S. 1632 and H.R. 1770, each health plan and self-insuring employer must contribute to a statewide insurance risk pool or else pay a 10-percent excise tax for not participating. These pools will then provide health care coverage to those financially risky persons who have previously been unable to obtain coverage due to poor health status. Each State would be responsible for designing and operating its risk pool, as long as the following requirements were met—deductibles would be limited to $2,500 a year, copayments would be limited to 20 percent, and total out-of-pocket payments would be limited to $3,500 per person per year. The pools would be regulated by the States, and dollar limits would be adjusted according to the Consumer Price Index medical care component.

While this bill would help only a small percent of those who are uninsured for health care costs, it would fill one of the many gaps in the private health insurance market. One major segment of the uninsured population likely to benefit from this bill is the pre-Medicare elderly, aged 55 to 64. Of the nearly 3 million persons over age 55 who do not have insurance, half are middle income individuals who would probably be able to afford insurance under the risk pool

mechanisms created by this bill. Thus, the risk pool would protect many people from becoming medically indigent, and would do so without increasing Federal spending.

#### *(2) Health insurance continuation*

While the risk pool bill did not pass, another initiative to help the uninsured was more successful. S. 1632, the "Health Insurance

Continuation Act of 1985", was introduced by Senator Heinz in September 1985, requiring group health insurance plans to allow continued access to coverage for spouses and their dependent children who had been previously covered, but, due to a change in family status, suddenly find themselves uninsured. Senators Kennedy and Durenberger introduced similar bills in the Senate, and Representative Stark introduced a similar bill in the House (H.R. 21). The continuation bill, like the risk pool concept, focused on one subgroup of the uninsured population—widowed or divorced spouses and their children. For these people, death or divorce carries an additional loss—that of their health insurance coverage. They are often ill-equipped to pay for expensive individual coverage, and may be barred from purchasing such coverage by pre-existing illnesses.

S. 1632 denied a business tax deduction for health insurance contributions to any employer who failed to provide 2 years of continuation coverage to the previously covered family members of deceased, divorced, or Medicare-eligible workers. After 2 years, the individual must be offered the right to convert to an individual policy with the employer's insurer.

The continuation bill also required that: Notification of eligibility for a continuation option would be made when a policy was issued; this option must be held open for a period of 90 days with full coverage maintained in the interim; continuation coverage is not conditional on any physical examination and entitles individuals to the same scope of benefits as similarly situated individuals provided under the group plan at the time of continuation; the insured spouse will pay both the employee and employer shares of the premium directly to the insurer unless other arrangements are made; and premiums shall not exceed the combined employer/employee premiums assessed for each similarly situated group member.

*Reconciliation provision.*—A modified version of this proposal was incorporated in the conference agreement for H.R. 3128, the Consolidated Omnibus Budget Reconciliation Act, still awaiting final action as of February 1986. Under the agreement, employers with 20 workers or more would be required to provide their employees the option of continued health coverage for 3 years in the case of a change in family status, or 18 months, if separated from employment. The conferees chose to apply three different Federal laws to ensure adequate enforcement of the provision: the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act.

### (C) FEHB

Seven FEHB plans announced their intention to offer rebates to Federal policyholders in 1985. According to the insurance companies, workers and retirees used medical services—and therefore health insurance—less in 1985, and at the same time paid a larger percentage of their medical bills. Thus, those seven plans saw premiums greatly exceed benefit payments, and are offering premium rebates ranging from $29 to $400 to more than 2 million Federal workers and retirees who were enrolled in one of the plans in 1985.

Current law, however, allows FEHB rebates to be given to "employees;" this definition excludes annuitants or retirees—former employees who pay into the plans on the same basis as employees—from receiving any rebates. To eliminate this inequity, the House and Senate passed H.R. 3384, which changed the rebate authority to allow annuitants to participate as well. That bill would also have eliminated the 75 percent cap on Federal contributions to FEHB premiums. Further, it would have authorized direct payment to certain non-physician health professionals, such as nurses and clinical social workers, without requiring that they be supervised by a physician. While the bill contained several other provisions, these three were the most critical to determining its fate.

On January 21, the President vetoed the bill and sent Congress a memorandum outlining his reasons. While he favored the provision which would allow retirees to share in the rebates being offered, he objected to the other two provisions. First, he stated that lifting the 75 percent cap on Federal contributions to premiums—without other cost containment reforms—would add to Government expenditures. Second, he stated that the provisions authorizing direct payment to nurses and other non-physician health practitioners should undergo greater congressional scrutiny, including hearings, before it is considered for enactment. He also questioned whether such a provision might conflict with various State laws regulating the scope of practice in which different professionals may engage.

The most immediate impact of the veto will be felt by annuitants of FEHB plans who cannot receive rebates until the law is amended. In order to expedite this change, Representative Oakar introduced on January 28, 1986, the "Federal Benefits Improvement Act of 1986" or H.R. 4061. This bill will enable annuitants to receive rebates, like H.R. 3384, but does not include the two provisions to which the President referred in his veto message: The provision lifting the 75 percent cap on Federal premium contributions has been included in the reconciliation bill, and was deleted from H.R. 4061. The provision regarding reimbursement for non-physician health practitioners has been modified so that, rather than mandating direct reimbursement, the bill instead calls upon OPM to study the feasibility of direct reimbursement for these providers. H.R. 4061 has been passed by the House and the Senate, and at the time of writing, is awaiting the President's signature.

### 4. PROGNOSIS

Legislative reform for retiree health benefits in the near future seems unlikely. However, the anticipated FASB ruling—requiring employers to list their retiree health benefit obligations as a financial liability—should prove to be an added stimulus for discussion and debate. Further, two studies due out shortly, one by the Department of Labor and the other by the Department of the Treasury, should produce valuable information about options for funding retiree health benefits.

There is a growing consensus that Congress must take steps to reduce the large number of medically uninsured Americans. Given concerns about the Federal deficit, however, it is clear that no major Federal spending program for the medically uninsured is going to emerge from the Congress in the near future. Based on the success of the health insurance continuation bill, it is evident that through the tax code and changes to ERISA, Congress is willing to encourage the private sector to increase the availability of health insurance coverage. It is an approach that could make significant inroads in reducing the number of uninsured among those Americans who work or who have spouses or parents who work. It will not, however, ease the problems of the millions of Americans who cannot afford health insurance.

## C. HEALTH RESEARCH AND TRAINING

### 1. Background

#### (A) NIH

Biomedical research is one of the most fundamental, yet often overlooked, ways to reduce the need for long-term care. The Federal Government's substantial investment in biomedical research for nearly four decades has resulted in America's unquestioned preeminence in science and health.

The National Institutes of Health (NIH) support extensive research on diseases of particular importance to the elderly. These include: cancer, diabetes, heart disease, stroke, organic brain disorders, arthritis, hypertension, cataracts, neurological disorders, and digestive diseases. The National Institute on Aging (NIA) focuses its research funds on easing or eliminating the physical, psychological, and social problems which affect the elderly population. Areas of biomedical and clinical research include studies on the genetic determinants of aging; the etiology, diagnosis, and treatment of Alzheimer's disease; osteoporosis and osteoarthritis; problems of drug use by the elderly; the impact of nutrition on aging; depression; sleep disorders; and exercise physiology in older persons.

#### (B) GERIATRIC TRAINING

Essential to effective, high quality, long-term care is an adequate supply of well-trained health care providers, including physicians, physicians' assistants, nurses, dentists, social workers, and gerontological aides. For decades, the Federal Government has supported the education and training of health care professionals by providing financial assistance through a variety of Federal and State agencies. This support was relatively unrestricted and unfocused; that is, it aimed at increasing the numbers of all types of health care professionals. By the mid-1970's, this generalized effort had proven successful. Congress was able to focus on particular problem areas in the supply of health care professionals, such as geographic and specialty maldistribution. Federal financial support was then focused on special projects; for example, more authorities were established by Congress to train primary care physicians, minority students, physician assistants, and so on.

## 2. Issues

### (A) REAUTHORIZATION

While the agency as a whole does not require reauthorization, several programs within NIH do need periodic reauthorization. Authority for the Cancer and Heart Institutes, the research training grants, and several smaller programs had all expired at the end of fiscal year 1983. The 98th Congress passed a bill, S. 540, that reauthorized the programs through fiscal year 1986 and made numerous changes in NIH. Among its provisions were the creation of two new Institutes (Arthritis and Nursing); the establishment of several additional new boards, commissions, and other entities; the specification of requirements concerning fetal research, animal research, and various management practices; and the recodification of NIH's statutory authority under the Public Health Service Act. The House and Senate approved the conference report in October 1984, but the President vetoed it after Congress adjourned. In his memorandum of disapproval, the President objected to the bill as unnecessary, expensive, unduly constraining on Executive branch authorities and functions, and burdensome in its managerial requirements.

In the 99th Congress, a similar bill, H.R. 2409, was introduced and vetoed. In his veto message, the President objected to the bill as an attempt by Congress to micromanage NIH and to thereby limit its ability to set the Nation's biomedical research agenda. The President's veto message characterized the bill as "imposing numerous administrative and program requirements that would interfere with the ability to carry forward our biomedical research activities in the most cost-effective manner and would misallocate scarce financial and personnel resources; establishing unneeded new organizations, which would lead to unnecessary coordination problems and administrative expenses while doing little to assist the biomedical research endeavors of NIH; and imposing a uniform set of authorities on all the research institutes, thus diminishing our administrative flexibility to respond to changing biomedical research needs."

Congress' response was a vote in both Houses which overwhelmingly reversed the veto. Senator Weicker argued that the bill did not unfairly restrain the flexibility within NIH to guide the Nation's research agenda, but only provided a reasonable and responsible measure of guidance by the Congress in setting research priorities which are responsive to the need of the people. He also stressed that the bill had undergone modifications to reflect the concerns expressed by the President in his veto message regarding S. 540 in 1984.

One provision of the bill which the President found particularly objectionable called for the creation of a National Center for Nursing Research. The administration found a lack of compatibility between research into patient care that would be conducted by such a Center and disease-oriented biomedical research that NIH conducts. Senator Heinz and several other Members defended the creation of the Center as a valuable step toward improving the quality of acute and long-term health care that will be needed by the growing elderly population.

### (B) FUNDING FOR NIH RESEARCH GRANTS

In the past few years, funding for NIH activites has increased steadily in response to strong congressional support for biomedical research and its commitment to maintain America's preeminence in science. Funding for NIH has generally exceeded the Reagan Administration's proposed budget levels. The administration's fiscal year 1986 budget request, for example, proposed reducing by 5 percent funding for new and competing renewal awards as well as noncompeting continuation awards. Congress rejected this proposal, but found that the continued strength of NIH research funding was threatened for a second time in 1985 by the Office of Management and Budget.

### (C) ALZHEIMER'S DISEASE

For the last several years, Congress has paid increased attention to the serious and growing problems related to Alzheimer's disease. Persons suffering from Alzheimer's disease require extensive long-term care services. This progressive, degenerative brain disorder affects an estimated 3 million persons, and the cost of caring for these patients was $38 billion last year. Alzheimer's disease is the fourth leading killer in the United States, and accounts for 120,000 deaths a year.

#### *(1) Research Into the Cause and Cure for Alzheimer's*

Research into the cause and treatment of Alzheimer's disease is supported by the National Institute on Aging, National Institute of Neurological and Communicative Disorders and Strokes, the National Institute of Allergy and Infectious Disease, and the National Institute of Mental Health.

Continued funding for research into the treatment and eventual cure for Alzheimer's is essential—yet it faces the same financial threat that jeopardizes all research programs today. The Alzheimer's Disease Research Centers, established by Congress in 1984, are an important component of the concerted national effort to find the cause and cure for this disease. Since funding began in 1984, the Centers have established special units to facilitate clinical and basic research, and programs in education and information transfer have been initiated. In fiscal year 1985, $3.5 million was provided for the five centers that were created in 1984, and each Center received $700,000. This amount, however, was far less than the support needed to complete the research projects approved for funding at each Center. In order to prevent high priority research proposals from being delayed, Chairman Heinz, Senator Glenn, and many other members of the Senate Aging Committee called for an additional $1.6 million appropriation for the Centers in fiscal year 1985.

Congress also called for the creation of five additional research centers in fiscal year 1985 with an appropriation of $5 million in the appropriations bill for the Departments of Labor, Health and Human Services and Education. In November 1985, it was announced that the five new centers would be located at the University of Pittsburgh, PA, the Washington University of St. Louis, MO, the University of Kentucky in Lexington, KY, the University of Washington in Seattle, WA, and Duke University in Durham, NC.

### *(2) Research into Ways to Assist Family Caregivers*

Given the growing numbers of elderly, especially the population aged 85 and older who are at greater risk of developing this disease, the demands on long-term care services over the next decades will be staggering. Alzheimer's disease is a major predictor of institutionalization, accounting for as many as 50 percent of the elderly in nursing homes, at an average cost of $17,000 per patient per year.

Although a large number of older persons with Alzheimer's reside in the community, often with family members, both groups—the institutionalized and the noninstitutionalized—are affected by significant gaps in the long-term care system in meeting the special needs of Alzheimer's patients and their families. The tremendous national effort to find a cure and treatment for Alzheimer's was precipitated largely by a greater understanding of the financial and emotional toll of the disease on family caregivers, as well as on victims.

Alzheimer's is often classified as a mental illness and therefore receives very little coverage under Medicare. Paradoxically, Alzheimer's victims eventually need continuous care which Medicare considers to be not skilled care but custodial care and therefore does not cover. Further, Medicaid coverage is only available to victims who spend down to poverty levels. Clearly, just as the disease causes victims to be physically dependent on their families, so do Federal health programs cause victims to be financially dependent on their families. Families are spending tens of billions of dollars each year to care for these victims, and often must do so while foregoing the income of a family member who must give up his or her career to attend to the victim.

At the request of Senator Heinz and several other Senators and Members of the House, a study is being conducted by the Office of Technology Assessment—and is due for release in mid-1986—which will analyze the reimbursement policies applied to Alzheimer's victims by Federal health programs, and will provide valuable recommendations for reforming those policies in ways which will relieve some of the financial burden now being borne exclusively by the victim and his family.

### (D) GERIATRIC TRAINING AND EDUCATION

To date, the Federal Government has yet to focus significant support on education and training in geriatric care. The House Committee on Appropriations, in its report on the fiscal year 1984 budget, requested the Department of Health and Human Services to submit a report with a plan of action for improving and expanding training in geriatrics and gerontology. In response to this, the NIA released its "Report on Education and Training in Geriatrics and Gerontology" in February 1984, assessing both the needs of the aging population and the ways in which the Federal Government could support needed education and training.

This report documents the shortage of and the projected need for personnel with training in geriatrics and gerontology. The report states that fewer than 300 medical school faculty members are involved in teaching some aspect of geriatrics today, but at least 1,350 will be needed to adequately staff medical schools in the year 2000; 8,000 geriatricians and 1,000 geropsychiatrists will be needed in 1990; the number of registered nurses in nursing homes and extended care facilities will have to double from 77,000 in 1980 to 150,000 in 1990; and the number of community health nurses with special training in gerontology and geriatric nursing will have to double, from 53,000 in 1980 to 106,000 in 1990. Similar increases will be needed in geriatric nurse faculty, geriatric dentistry faculty, geriatric social workers, social work faculty, social gerontologists and gerontological aides, and others.

Current resources to provide education and training in geriatrics and gerontology are very limited. The NIA report estimates that only about 1 percent of expenditures for training and research in the health field is concerned specifically with aging and the aged. Overall obligations for Department of Health and Human Services training programs in geriatrics and gerontology amounted to approximately $40 million for 1985.

## 3. Legislation

### (A) HEALTH RESEARCH EXTENSION ACT OF 1985

Passage of H.R. 2409, the "Health Research Extension Act of 1985," extending the statutory authorization of the National Institutes of Health and National Research Institutes, brought several substantive changes to the organization of NIH that should prove beneficial to the health status of the elderly. First, the act establishes a new National Institute of Arthritis and Musculoskeletal and Skin Diseases. It is estimated that arthritis and other musculoskeletal diseases affect over 37 million Americans and that more than $1 billion is spent each year on unproven remedies and quackery. The National Institute on Arthritis and Metabolic Diseases, established in 1950, has become a multi-focused Institute grouping together 10 disparate research programs. The creation of this new Institute will allow a focused national effort on research into the prevention, diagnosis, treatment, and eventual cure of arthritis and related debilitating diseases.

The Act also created a National Center for Nursing Research within NIH to provide a focal point for promoting the growth and quality of research related to nursing and patient care, to provide leadership to expand the pool of experienced nursing researchers and to promote closer interaction with other bases of health care research. Programs at the new Center will be directed primarily toward basic and applied research related to patient care, the promotion of health, the prevention of illness, and the understanding of individual, family, and community responses to acute and chronic illness and disability.

Second, the act requires the Secretary of DHHS to conduct a study which will provide a description of the health personnel needed to meet the health needs of the elderly for the next four decades. The study, to be presented to Congress by March 1, 1987, is to include recommendations for specific numbers of personnel that will be needed, including primary care physicians, psychiatrists, and other physician specialists, as well as other non-physician health personnel. The requirement of the study is evidence of the growing recognition of the need to develop leadership cadres of teachers and researchers in geriatrics. The study should prove to be a valuable guide in developing legislative and policy recommendations to assure the training of an adequate supply of health personnel to meet the expected health care and needs of the elderly.

### (B) NIH APPROPRIATIONS

The budget approved by Congress for fiscal year 1985 would have enabled NIH to fund some 6,500 new and competing grants, about 1,500 more than in the previous year. Continued funding for those new grants in succeeding years would require a continued increase in the NIH research budget. In order to circumvent that, OMB directed NIH to fund only 5,000 new grants in fiscal year 1985—a level below the previous year's level of 5,493—thereby reserving a portion of the fiscal year 1985 funding to support the continuation of those grants in fiscal year 1986. The net effect would have been to reduce considerably the funds needed in the fiscal year 1986 budget request for continuation of noncompeting grants. Similar adjustments were also proposed for fiscal year 1985 support of research centers.

In response to OMB's action, joint resolutions were introduced in both the House and the Senate to overturn the OMB directive and require that NIH receive its full funding for research project grants as appropriated. Negotiations between the administration and the appropriations committees arrived at a compromise level of support for fiscal year 1985 grants that is included in the conference report on the fiscal year 1985 supplemental Appropriations Act. This compromise calls for the support of at least 6,200 new and competing research projects and 533 research centers from funds appropriated for fiscal year 1985, with not more than $20 million of the appropriation to remain available for obligation through fiscal year 1986. No multi-year funding of grants is authorized.

Congress' intent to continue support for biomedical research is evident in the Labor-HHS Appropriations Act for fiscal year 1986 which calls for funding of no less than 6,000 new and competing grants through NIH, a slight decrease from the compromise level reached for 1985. However, NIH funds for fiscal year 1986 are not yet safe—it is anticipated that the administration will request large-scale budget rescissions in the fiscal year 1986 DHHS budget and that the biggest single cut would come from funds for NIH research centers.

### (C) ALZHEIMER'S DISEASE BILLS

At a hearing before the House Select Committee on Aging on May 14, 1985, entitled "Caring for Our Nation's Alzheimer's Victims," witnesses documented the failure of Medicare and Medicaid to adequately provide for the health and mental health care needs of the victims of Alzheimer's disease. In response, the participants in the Labor-Health and Human Services fiscal year 1986 appropriations act conference suggested that HCFA institute studies on the improvement of Medicare and Medicaid eligibility and benefits with respect to Alzheimer's disease and related disorders. The act also included a $2 million appropriation for the creation of a national Alzheimer's disease registry, which would become the repository of the state-of-the-art knowledge about the diagnosis and treatment of Alzheimer's.

Several bills on the subject of Alzheimer's were introduced during 1985, but none were enacted. Representative Roybal introduced H.R. 2280, the "Comprehensive Alzheimer's Assistance, Research, and Education Act (CARE) of 1985," to deal not only with research but also patient and family services as well. The bill proposes: a national Alzheimer's disease education network to provide information and assistance to health care providers and to victims' families; model State programs to encourage the development and coordination of services for victims and families, allowing up to 25 percent of the funds to be used to provide respite care services; support for Medicare and Medicaid projects to explore alternative health delivery and adjustments for nursing home reimbursements; and expansion of the number of specialized Alzheimer's disease research centers. Senator Pressler introduced a similar bill in the Senate. Several other bills were introduced to provide tax credits to taxpayers who provide care for Alzheimer's victims, but none were enacted. The House Appropriations Committee, in its report accompanying the fiscal year 1986 Labor-HHS appropriations bill, directed the DHHS Secretary's Task Force on Alzheimer's Disease to submit a report on Alzheimer's to the committee prior to the hearings on the fiscal year 1987 budget. That report is to describe how the various States cover Alzheimer's patients under their Medicaid programs, paying particular attention to the problems faced by families in gaining eligibility; the development of innovative methods of caring for patients suffering from Alzheimer's disease and other dementing disorders within the nursing home setting; and alternatives to nursing home care that exist for these patients.

### (D) GERIATRIC RESEARCH EDUCATION AND TRAINING

In order to address the lack of funding and coordination for geriatrics and gerontology, Chairman Heinz and Senator Glenn introduced S. 1100, the "Geriatric Research, Education and Training Act of 1985." This bill would authorize more than a doubling of funds over a 3-year period for geriatric education and training. The bill was proposed as a cost-saver in that increased geriatric education would result, not in more doctors, but rather in more appropriately trained doctors; it would not increase the total number of providers being trained, but rather would redirect their training to better prepare them to effectively and efficiently treat elderly patients.

The bill has not yet been enacted, but it has served to sensitize Congress to the importance of supporting appropriate medical education. For example, later moves to reform Medicare contributions to the costs of graduate medical education were tailored to continue support for geriatric training at Senator Heinz' urging. Further, the conferees for H.R. 2409, the "Health Research Extension Act of 1985," agreed that "there has been inadequate attention paid to the need to train doctors and other health professionals to deal with . . . the health needs of the elderly." Therefore, as noted previously, they ordered the Secretary of DHHS to report to the Congress by March 1, 1987, with recommendations for the specific numbers and types of health personnel that will be needed to meet the health needs of the elderly for the next four decades, and to include legislative and other policy recommendations necessary to assure the training of an adequate supply of health personnel.

# Chapter 8

# LONG-TERM CARE

## OVERVIEW

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private medigap insurance. As a consequence, many elderly persons and their families pay the full cost of their care out-of-pocket. The cost of long-term care has become the single greatest threat to the financial security of older Americans.

Significant improvements in long-term care financing and delivery are not on the immediate horizon. The reluctance to implement new long-term care initiatives can be attributed to three factors. First, the 6 million older Americans who need long-term care are a relatively new phenomenon—with no tradition to help mobilize congressional interest or action. Second, the enormous costs of improving access to long-term care services for the elderly tends to deter interest in comprehensive legislative reform. Third, there is no current consensus on the best way to provide long-term care.

The need for improvement in long-term care has grown more pressing. This year, a series of hearings held by the Senate Special Committee on Aging disclosed a new and troublesome trend. It was determined through these hearings that Medicare beneficiaries are being discharged from hospitals "sooner and sicker," in large part because of the implementation of the Medicare prospective payment system (PPS). More importantly, these sicker beneficiaries are being discharged into the already strained long-term and subacute care system. Therefore, many Medicare beneficiaries are not able to obtain the continued care they often need after hospital discharge.

Federal initiatives to provide long-term care are lacking. The theory behind implementation of PPS was that patient length of stay in costly hospitals would be decreased and that greater amounts of less costly continued care would be provided in the home or nursing home setting. This substitution is occurring, but the Health Care Financing Administration under the Department of Health and Human Services (DHHS) appears to be limiting reimbursement for those substitute services. In the face of enormous Federal deficits, few observers expect the Congress to tackle a major new long-term care initiative in the near term.

Private initiatives, on the other hand, are more encouraging. There is a growing awareness among employers and private health insurers of the importance of protection against long-term care costs. Several major commercial health insurers have already indicated an interest in pursuing the long-term care insurance market.

## A. BACKGROUND

### 1. Types of Long-Term Care

The phrase "long-term care" encompasses a wide array of services offered in a variety of settings ranging from institutional settings (e.g., nursing homes) to noninstitutional settings (e.g., adult day care centers and a person's own home). Community-based long-term care typically encourages a variety of noninstitutional health and social services such as home health care, homemaker, chore and personal services, occupational, physical and speech therapy, adult day care, respite care, friendly visiting, and nutritional and health education.

Long-term care services incorporate the needs of two different types of patient. Some long-term care services meet the health care needs of subacute patients who have recently been discharged from a hospital, while other patients with chronic conditions require care in a nursing home or other facility for an extended period of time.

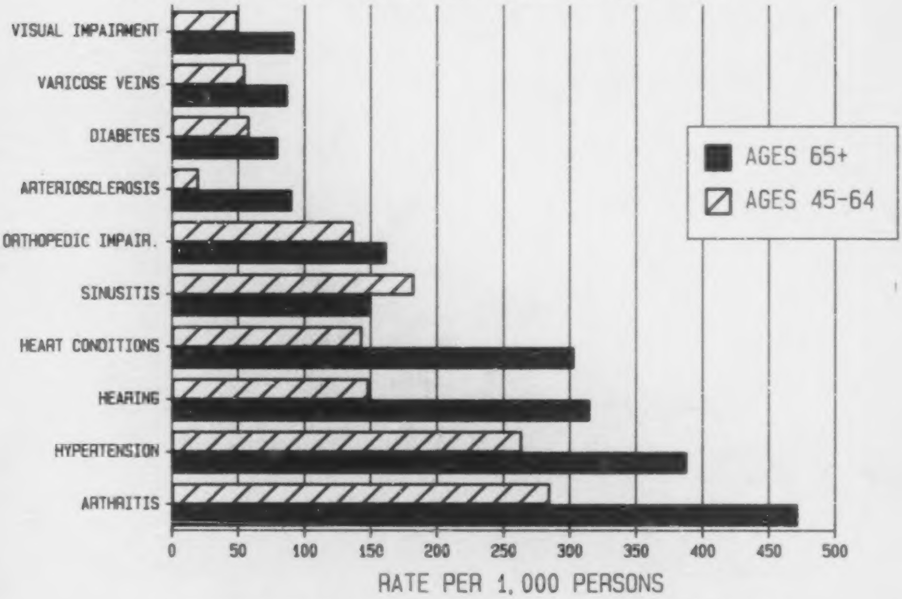
Access to long-term care by discharged patients is a growing problem. In hearings before the Senate Special Committee on Aging, it has been established that while the prospective payment system is causing Medicare patients to be discharged sooner and sicker from hospitals, too often, these patients do not have access to needed home health and skilled nursing care. While the problem of access to needed post-hospital care is not new, it has worsened under the incentives of the prospective payment system.

The second category of long-term care patients is the more traditional patient: Those with functional disabilities, mental disorders, and other nonacute ailments that require maintenance or custodial care over long periods of time. Long-term care for these patients is characterized by extended medical, personal, social, and psychological care at home or in institutions. The need for long-term care coincides not with particular medical diagnoses, but rather with chronic physical or mental disabilities that impair functioning.

Chronic conditions are problems of aging and, as such, are responsible for a large portion of the Nation's health expenditures. However, most older persons are able to live independently in spite of these conditions. According to the 1981 data from the National Center for Health Statistics' National Health Interview Survey, about 18 percent of older persons report that they can no longer carry on normal activities because of chronic conditions. For the 1981 population of persons over age 65, the leading chronic conditions were arthritis and hypertensive disease.

CHART 8-1

PREVALENCE OF TOP TEN CHRONIC CONDITIONS: 1983

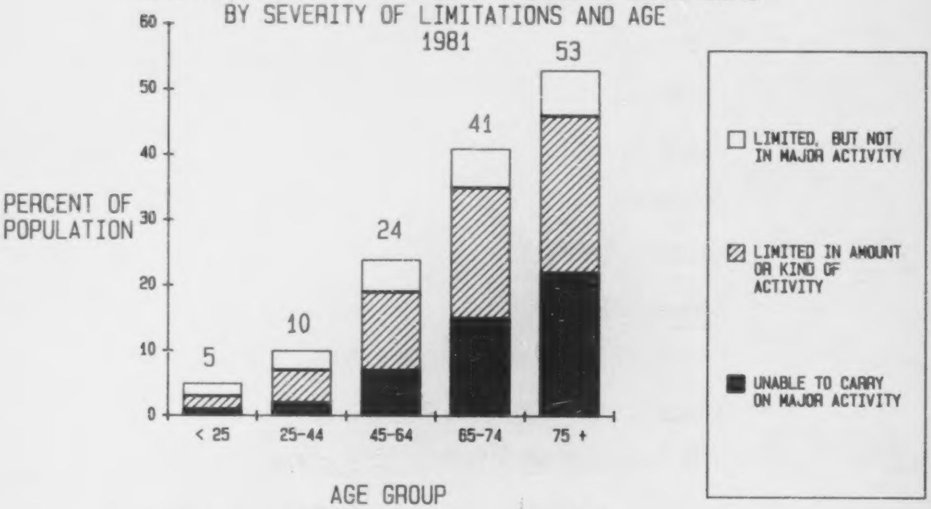


SOURCE: National Center for Health Statistics, Division of Health Interview Statistics

A significantly higher proportion of persons age 65 and older than persons under age 65 are limited in their abilities to perform normal daily activities due to a chronic condition. As shown in Chart 8-2, it is those over age 75, who are most hindered by chronic conditions.

CHART 8-2

LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS
BY SEVERITY OF LIMITATIONS AND AGE
1981



SOURCE: National Center for Health Statistics,
1981 Health Interview Survey, unpublished

## 2. Numbers of People Receiving Long-Term Care

### (A) NURSING HOME CARE

In 1980, nearly 12 million elderly citizens had some degree of limitation of daily activity due to chronic conditions, but only a small fraction were confined to a long-term care institution. While 90 percent of all nursing home residents are 65 years old and older, in 1980, only 1.2 million older Americans were confined to nursing homes. By the year 2000, however, this population will grow to 2.2 million people, and to 4.5 million by the year 2040.[1]

Approximately 12 percent of the population over age 65, and 2 percent under age 65, or a total of about 5 million people, require some assistance in performing the activities of daily living. Other groups requiring some measure of long-term care include the mentally retarded, the developmentally disabled, and the adult chronically mentally ill.

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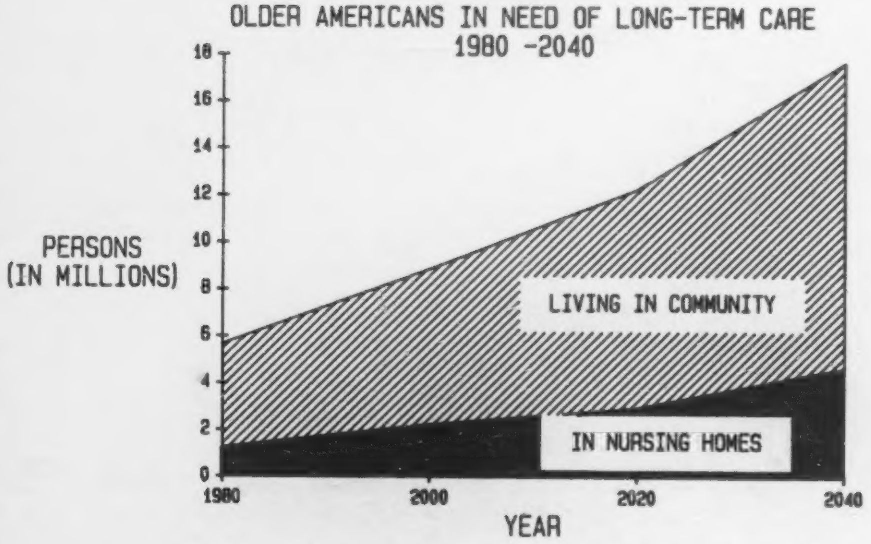
[1] Developments in Aging 1984, p. 190.

CHART 8-3



OLDER AMERICANS IN NEED OF LONG-TERM CARE
1980 -2040

SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

A large proportion of noninstitutionalized older Americans may be in need of more extensive long-term care. According to the National Center for Health Statistics, 2.1 million of the noninstitutionalized elderly need help in one or more basic physical activities and 2.4 million elderly need the help of another person in carrying out home management activities. In addition, approximately 425,000 of the noninstitutionalized elderly usually stay in bed all or most of the time because of a chronic health problem.

For some of these very dependent people, the nonavailability of beds is a factor preventing their placement in nursing homes. While there are no firm nationwide estimates of the potential needed supply of nursing home beds, nursing home occupancy rates have historically been very high, estimated at 92.4 percent in 1980. In addition, certain localities report a short supply of beds as measured by the numbers of long-term care patients backlogged in acute care hospitals awaiting discharge to a nursing home.

Although only 5 percent of all older Americans are likely to be in a nursing home at any given time, that likelihood increases with age. While only 1 out of every 100 persons in the 65 to 74 age group is in a nursing home on a given day, 7 out of 100 persons in the 74 to 84 age group and 20 out of 100 persons in the 85-plus age group are in a nursing home on any given day.[2] With rapid growth in the oldest age group will come increased demands for nursing home care.

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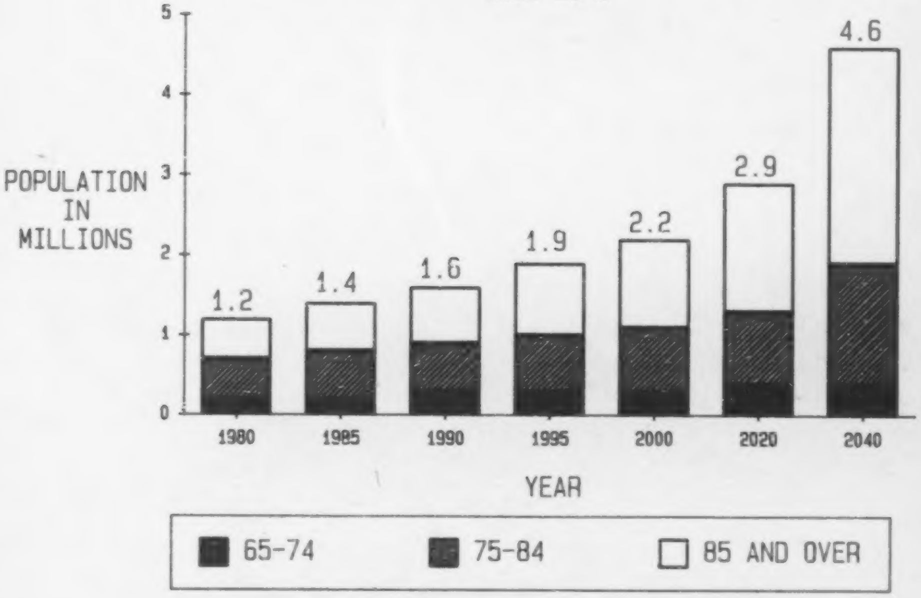
[2] National Center for Health Statistics, 1977 National Nursing Home Survey.

CHART 8-4

NURSING HOME POPULATION PROJECTIONS
PERSONS 65 YEARS AND OLDER BY AGE GROUP
1980-2040



SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

### (B) HOME HEALTH CARE

For every person 65 years of age and over residing in a nursing home there are nearly four times as many living in the community requiring some form of long-term care. The 1982 National Long-Term Care Survey estimated that approximately 4.6 million noninstitutionalized elderly Americans—about 18 percent of the over 65 population—had limitations in activities of daily living (ADL's) and instrumental activities of daily living (IADL's). Limitations in ADL's reflect dependence in certain basic self-care functions such as bathing, dressing, and eating, and limitations in IADL's refer to levels of disability in the performance of a daily routine, including shopping, cooking, and cleaning. The 1982 survey found that approximately 850,000 elderly individuals were residing in the community with severe limitations in activities of daily living.

Of the 4.6 million disabled elderly, almost 70 percent relied exclusively on nonpaid sources of home and community health care. Almost 1 million received at least some paid care and only 240,000 used paid care only. Of those who received both paid and unpaid care, nearly 41 percent were sole payors for this care, Medicare paid for community care for 8.4 percent of this group and Medicaid paid for about 6 percent. Private insurance pays only about 1 percent of the Nation's long-term care bill.

## 3. COVERAGE AND FINANCING

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, inkind transfers, or the provisions of goods and services. Most of the public sector's expenditures for long-term care services, however, are for institutional care—primarily for nursing homes.

In 1985, total expenditures for nursing home care were an estimated $32 billion. Between 1965 and 1983, the total cost of nursing home care increased 7 percent above the rate of inflation, and is projected to continue rising an average of 4.7 percent above inflation each year between 1983 and 1990.[3] In constant dollars, total nursing home expenditures will increase by more than 50 percent between 1980 and 1990. Almost 50 percent of nursing home expenditures was financed by Federal, State, and local governments.

By far the largest portion of public expenditures for nursing home care is financed by the Medicaid Program for the poor and medically indigent. In 1984, Federal, State, and local Medicaid expenditures for nursing home care amounted to $13.9 billion—representing 43 percent of total national spending, 89 percent of public spending for nursing home care, and 38 percent of total Medicaid spending for all covered health care services.

By way of contrast, the Medicare Program accounts for only a small portion of the Nation's expenditures for nursing home care. Medicare's expenditures amounted to $600 million and represented less than 2 percent of national spending and 3.8 percent of public spending for nursing home care in 1984.[4]

### (A) MEDICAID

#### *(1) Coverage*

The Medicaid Program, which provides medical assistance for certain low income persons, excludes most older Americans. Medicaid has nonetheless become the primary source of public funds for nursing home care. Approximately 89 percent of all public expenditures for nursing home care is paid by Medicaid. Each State administers its own program and, subject to Federal guidelines, determines the Medicaid income eligibility standard.

State Medicaid programs are required by Federal law to cover the categorically needy, that is, all persons receiving assistance under the Aid to Families with Dependent Children (AFDC) program and most people receiving assistance under the Supplemental Security Income (SSI) program. States may also cover persons who would be eligible for cash assistance, except when they are residents in medical institutions, such as skilled nursing facilities (SNF's) or intermediate care facilities (ICF's).

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[3] Developments in Aging 1984, p. 196.

[4] Carol O'Shaughnessy, Richard Price, and Jeanne Griffith, Financing and Delivery of Long-Term Services for the Elderly, Library of Congress Congressional Research Service, October 17, 1985, updated, p. 15.

In addition, States may, at their discretion, cover the medically needy, that is, persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enough to pay for medical care. These State variations mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

To control costs and to provide a range of community-based services to the Medicaid-eligible population, many States have applied to the Department of Health and Human Services (DHHS) for section 2176 Medicaid waivers. In 1981, Congress established these waivers, giving DHHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a SNF or ICF. Services covered under the 2176 waiver include case management, homemaker, home health aide, personal care, adult day care, rehabilitation, respite, and others. While this new waiver option has been enthusiastically received by the States, there is concern about the administration's support for the 2176 waiver program, as is discussed later in this chapter.

### *(2) Expenditures*

Federal Medicaid expenditures for nursing home care in 1984 were over $10 billion, of which an estimated $4.8 billion was spent on SNF's and $5.7 billion for ICF's. Medicaid financed 89 percent of Federal spending and 43 percent of total nursing home expenditures. Even though the elderly and disabled constitute only about one-third of the Medicaid eligible population, they account for more than two-thirds of Medicaid expenditures. More striking, nursing home residents comprise only 7 percent of all Medicaid recipients, but account for almost 50 percent of all costs.[5]

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In 1984, Federal Medicaid expenditures for home health care were $270 million, accounting for less than 1 percent of total Medicaid spending. In 1982, the last year in which these data were collected, home health benefits constituted more than 1 percent of total Medicaid expenditures in only nine States. One State, New York, spent 78 percent of all Medicaid home health dollars.[6]

Because Medicaid expenditures consume between 10 to 15 percent of State budgets, many States are seeking to control the growth of their nursing home population and their obligated Medicaid expenditures. As many as 26 States made changes in nursing home reimbursement policies to reduce costs in 1981 and 1982, with several States adopting a preadmission screening process and limits for the number of beds reserved for Medicaid beneficiaries.

As chart 8-5 shows, the projected increases in nursing home expenditures will compound the difficulties currently experienced by States in covering nursing home care.

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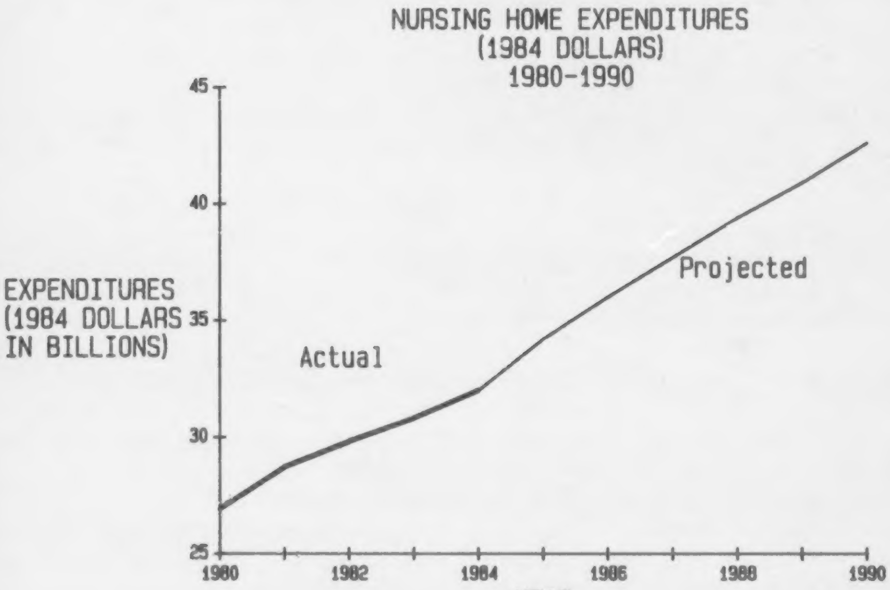
[5] Health Care Financing Administration, 1982 unpublished data.

[6] Health Care Financing Administration, 1984 unpublished data.

CHART 8-5



SOURCE: HCFA unpublished estimates

### (B) MEDICARE

### *(1) Coverage*

The Medicare Program, which insures 95 percent of all older Americans without regard to income or assets, does not cover either long term or custodial care. Primarily, it provides acute care coverage for those age 65 and older, particularly hospital and surgical care and accompanying periods of recovery. For example, Medicare covers up to 100 days of SNF services following a hospital stay of at least 3 consecutive days. Further, in order to receive reimbursement under Medicare, the patient must be in need of skilled nursing care on a daily basis for treatment related to a condition for which he or she was hospitalized. The SNF benefit is subject to a daily patient copayment after the 20th day of care. In 1985, the copayment is $50 per day, rising to $61.50 in 1986. The program pays for neither intermediate care facility services nor custodial care in a nursing home.

Even though Medicare coverage of home health care is only for short periods of care and only for treatment of an acute care condition or for post-acute care, the Medicare home health benefit is the fastest growing component of the Medicare Program.

Home health services covered under Medicare include the following:

- —part time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse,
- —physical, occupational, or speech therapy,
- —medical social services provided under the direction of a physician,
- —medical supplies and equipment (other than drugs and medicines),
- —medical services provided by an intern or resident enrolled in a teaching program in a hospital affilitated or under contract with a home health agency, and
- —part time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to the home and under the care of a physician. In addition, the person must be in need of part time or intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. The patient is not subject to any cost-sharing, e.g., deductibles or coinsurance, for covered home care.

In addition to these SNF and home health care benefits, Medicare covers a range of long-term care services, and especially home care services, for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, therapy services, medical social services, home health aide services, physician services, counseling, and short term inpatient care. For fiscal year 1986, HCFA estimates that Medicare expenditures for hospice care will amount to $30 million.

There is no statutory limit on the number of home health visits covered under Medicare; but according to HCFA, home health care should generally be available for just a few weeks. HCFA's recent attempts to restrict use of the home health benefit have been the subject of congressional hearings and legislation, discussed in more detail later in this chapter.

While coverage of long-term care services is restrictive and limited, older Americans apparently believe that Medicare's coverage includes basic long-term care services. In fact, a recent survey by the American Association of Retired Persons (AARP) found that of older persons surveyed, fully 79 percent believed that Medicare would pay for part, if not the entire cost, of their nursing home care.

### *(2) Expenditures*

Medicare expenditures for long-term care have generally been small. In 1985, Medicare's contribution to SNF care was only $600 million, approximately 0.02 percent of total public and private spending for nursing home care and less than 1 percent of total Medicare spending.[7]

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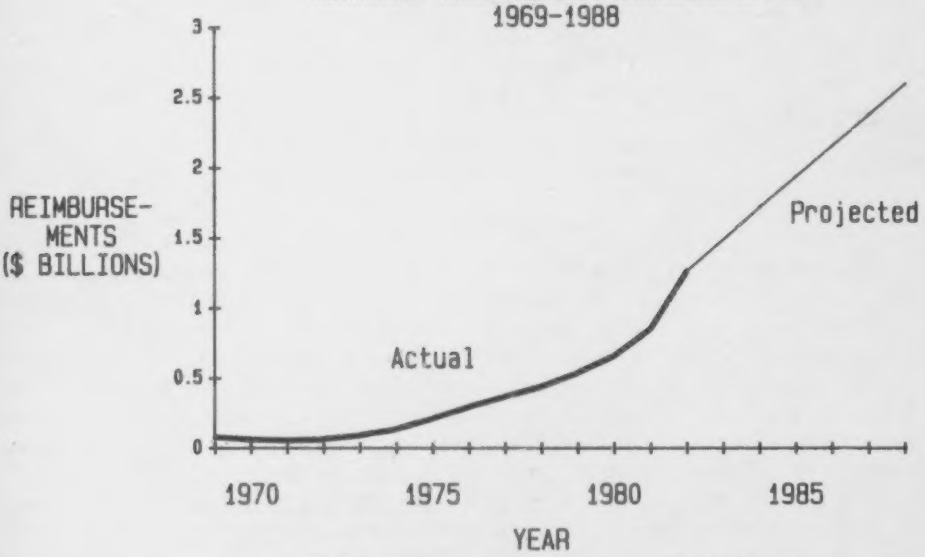
[7] O'Shaughnessey, et. al., p. 15.

Medicare payments for home health care comprise less than 3.1 percent of total program outlays. For fiscal year 1984, total reimbursements for Medicare home health services were about $1.9 billion. Chart 8-6 indicates, however, that Medicare's home health benefit expenditures are the fastest growing component of the Medicare Program.

CHART 8-6

MEDICARE HOME HEALTH REIMBUSEMENTS
1969-1988



SOURCE: HCFA/Bureau of Data Management and Statistics

### (C) TITLE XX

### *(1) Coverage*

Title XX of the Social Security Act authorizes reimbursement to States for social services, now distributed via the Social Services Block Grant (SSBG). Among other goals, the SSBG is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are not appropriate.

Although the SSBG is the major social services program supported by the Federal Government, its ability to support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the title XX program has competing demands and can only provide a limited amount of care to the older population.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated. Data concerning the extent to which title XX now supports long-term care is therefore unavailable.

### *(2) Expenditures*

States receive allotments of SSBG funds on the basis of the State's population, within a Federal expenditure ceiling. There are no requirements for use of title XX funds—States are provided relative freedom to spend Federal social service block grant funds on State-identified service needs. Legislation in the 98th Congress permanently increased the per year expenditure ceiling to $2.7 billion, effective in fiscal year 1984. In fiscal year 1985 the appropriation level was $2.7 billion, and on December 12, 1985, the fiscal year 1986 Labor, HHS, and Education appropriation bill was signed into law (Public Law 99-178) which included a level $2.7 billion for the SSBG.

## (D) THE OLDER AMERICANS ACT

### *(1) Coverage*

The Older Americans Act (OAA) carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, civic, cultural, and recreational opportunities, and social services. While the OAA thus funds a wide range of supportive services, in-home services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by Congress. Each OAA area agency on aging is required to spend a portion of its supportive services allotment on home care services.

The number of home care visits to older persons supported under the OAA represents only a small fraction of the amount under Medicare and Medicaid. The OAA services, however, are provided without the restrictions called for by Medicare and without the income tests called for by Medicaid. In some cases, OAA funds may be used to serve persons whose Medicare and Medicaid benefits have become exhausted or who are ineligible for Medicaid. Approximately 2.4 million in-home service visits were provided under the OAA in 1984.

### *(2) Expenditures*

Unlike the title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of title III funds for supportive services, for congregate nutrition services and for home-delivered nutrition services. States receive allotments of these funds according to the number of older persons in the State as compared to all States. The law gives States and area agencies on aging some flexibility to define the supportive services to be provided and to transfer funds among the three service categories. Total fiscal year 1985 appropriations for title III were $669 million. Fifty percent of the funds, or $336 million, were for congregate nutrition services, and 40 percent, or $265 million, were for supportive services and senior centers. Only about 10 percent of the Federal appropriations, or $68 million, was devoted to home-delivered nutrition services. Fiscal year 1986 funding, approved in the Labor, HHS, and Education appropriations bill, remained at fiscal year 1985 levels.

### (E) PRIVATE INSURANCE

#### *(1) Medigap*

Two in every three older Americans purchase supplemental medical insurance, or medigap policies. These policies are typically designed to supplement Medicare's coverage of acute care costs, not long-term care costs.

To illustrate, some medigap policies cover the daily copayment from the 20th to the 100th day of an approved stay in a Medicare SNF. Others provide coverage for skilled care, as defined by Medicare, in a certified facility for stays of 100 to 365 days, or longer. The value of medigap coverage for long-term care, however, is very limited. These policies generally cover a very small fraction of total nursing home costs and an even smaller portion of home health or custodial care costs.

#### *(2) Long-term care insurance policies*

Currently, only about 1 percent of the Nation's long-term care expenditures is paid for by private insurance, and only about 50,000 individuals currently hold private long-term care policies. At least 12 companies currently write individual long-term care insurance policies which are substantially more comprehensive than standard medigap policies. These policies offer indemnity benefits for 3 to 4 years of care in a licensed nursing care facility. In all cases, coverage continues after the need for skilled nursing care is fulfilled and the long-term care needs become custodial in nature.

There are several common features of the types of benefits offered by these companies. First, they all offer indemnity benefits ranging from $10 to $50 per day. Offering an indemnity benefit, rather than paying the total costs of nursing home services, limits the insurer's liability and thereby reduces the risk of the policy to the insurer.

Second, all policies are offered with either a deductible or a reduced benefit for some initial period of time. This ensures that the more frequent short stays do not increase the cost of insuring the less frequent, but more expensive, long stays. In effect, these policies protect against catastrophic costs and are more like casualty insurance than traditional health insurance. only individuals with extended stays are fully eligible for many plan benefits.

Third, all policies are to some extent oriented to a stay in a SNF or care in a facility with a full-time nurse. By excluding home care benefits, it is easier for the insurer to define the insurable event and thereby, to limit the insurer's liability.

These factors reduce the cost of the policies, but may also reduce both their desirability to many persons and their effectiveness in reducing overall costs. These characteristics of private long-term care insurance may also turn out to be an obstacle to efforts that are underway to stimulate a shift from institutional care to home care.

### (F) OUT-OF-POCKET COSTS

#### *(1) Expenditures*

While the cost of long-term care represents an increasing share of Federal and State budgets, relatively few older Americans have access to publicly financed services. The cost of nursing home care and home and community-based care often falls on individuals and their families.

The vast majority of the chronically ill and disabled elderly population rely exclusively on informal support. Between 70 and 80 percent of these elderly persons living in the community who need long-term care receive all of the care they need from family and friends. The remaining 20 to 30 percent pay for their care themselves, or have some or all of their care paid for by private insurers, Medicare or Medicaid, and family members.[8]

Home care is generally a less expensive option for the elderly, but about 14 percent have out-of-pocket costs for home care that range from $360 to $1,680 per year, depending on the level of disability.[9] These out-of-pocket costs are only for home care, they do not include other health-related expenses, such as prescription drugs, or the other community-based services needed by many functionally impaired individuals.

The cost of community-based care pales in comparison to the cost of nursing home care. The price of a year in a nursing home ranges from $12,000 to $50,000; the cost at even the lower end of this range is beyond the resources of most older Americans. Thus, many elderly people must spend their entire savings and become eligible for Medicaid soon after they enter a nursing home. Currently, between one-quarter and two-thirds of the patients who enter nursing homes as private paying patients subsequently spend down their resources and become eligible for Medicaid. A recent study released by the House Select Committee on Aging shows that this spend down occurs on the average within 13 weeks after admission.

## B. ISSUES

### 1. DEMAND FOR LONG-TERM CARE EXCEEDS SUPPLY

The group of seniors known as the "oldest-old," those 85 years of age and older, is the fastest growing segment of our population—and the segment most in need of long-term care. The 85-plus population has grown 165 percent from 1960 to 1982, and is expected to grow another 400 percent between 1985 and 2030.[10] The rate of nursing home use increases dramatically with age. These rates are closely tied to the fact that the oldest-old are prone to chronic disabilities and therefore have greater need for supportive services.

The elderly experience a high incidence of chronic conditions. According to the National Center for Health Statistics, half the population over 75 years of age suffer limitations in activities of daily living. Among the chronic conditions, dementia and incontinence are prime indicators for nursing home admission.

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[8] Developments in Aging 1984, p. 197.

[9] 1982 National Long-Term Care Survey.

[10] Trends and Strategies in Long Term Care, American Health Care Association, 1985, p. 3.

Other factors greatly influence the rate of demand for long-term care services. As the population ages, there will be more people in the 85-plus age group living without a spouse—a major factor affecting nursing home utilization. Families are becoming less and less able to care for older relatives in their own homes as families are more geographically dispersed, and women—the traditional caregivers—are entering the workforce with increasing frequency.

Women face a higher risk of institutionalization than do men for several reasons. First, women live longer than men and this trend is expected to continue. A second related factor is that women more often than men live alone in later years. Among the older population, men are twice as likely to be married, while women are four times as likely to be widowed. Third, women have a higher incidence than men of chronic disorders. Studies show that men have higher rates of fatal diseases, while women have greater incidence of long-term chronic diseases.[11]

These trends have enormous consequences for the long-term care system and for our society at large as more Americans will be more in need of long-term care than ever before. For seniors, it means that they may find themselves in need of care with no care available, or only very costly care that may deplete their life savings. The Nation must find ways to finance long-term care, especially as expenditures for nursing home care are expected to rise from $34.6 billion in 1980 to $55.1 billion in 1990. Society may find itself facing enormous shifts in public and private dollars toward long-term care services.

This fundamental change has not gone unnoticed. Key actors on all sides of the issue have already begun advocating the need to reform current long-term care policies to keep pace with the change. Many long-term care providers advocate expansion of Medicare and the development of long-term care insurance and individual medical accounts to provide greater coverage for long-term care. The elderly and their families have traditionally assumed that Medicare coverage will meet this increased need—in fact, a recent AARP study shows that four out of five older Americans assume that Medicare will pay for long-term nursing home care.

Congress finds itself in the predicament of having to weigh human concerns against economic pressures and is reluctant to expand coverage of the Medicare benefit for fear it will grow out of control. States, too, are nervous about the Federal Government's continued acquiescence to Medicaid as the principal financing mechanisms for the Nation's long-term care needs. Most Federal budgetary reductions, which have been passed onto the States, occurred at a time when States already were dealing with large deficits due to general economic conditions. As a result, many States have been forced to severely constrain spending for long-term care.

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[11] Ibid., p. 4.

### (A) NEW SUBACUTE CARE PATIENT

As a result of the Medicare prospective payment system, the elderly are being released from hospitals sooner and sicker than they have been in the past. This sicker patient often needs a more intensive form of post-hospital care.

At the same time, many of these patients have care needs that are greater than the levels of care available in traditional extended care settings. This new long-term care patient has created a demand for a new type of provider—one who is subacute, yet intensive enough to meet existing needs.

Unfortunately, access to Medicare SNF and home health benefits, which are designed to care for the post-acute population, have been limited for these patients. Interpretations of eligibility critera vary greatly from State to State and many SNF and home health care providers have been reluctant to accept Medicare beneficiaries out of fear that Medicare may retroactively deny coverage for those patients.

Retroactive denials have become more of a threat to post-hospital health care providers with HCFA's attempt to eliminate the waiver of liability as well. Waiver of liability for skilled nursing facilities and home health care agencies was enacted as part of the 1972 Social Security amendments. This waiver means that, within certain limits, where neither the beneficiary nor the provider knew or could have been reasonably expected to know that services were not covered by Medicare, neither the beneficiary nor the provider would be responsible for the cost of those services. The purpose of this rule is to protect beneficiaries and providers from unexpected decisions made retroactively that certain services were not covered.

### (B) THE AGING VETERAN

The proportional growth in the number of elderly veterans is expected to greatly exceed the growth rate of the total 65-plus population, and the rapid growth in the veteran population will occur much sooner than will the growth in the older population as a whole. The number of veterans aged 65 and older—now approximately 4 million—is expected to double by 1990, and to triple by the year 2000 with the aging of World War II and Korean war veterans. By 1990, 1 of every 2 American men older than 65 will be eligible for VA benefits. By the year 2000, two-thirds of all American men over 65 will be veterans. Under current eligibility rules, all of these veterans will be eligible for free medical and long-term care from the VA.

This aging trend among the veteran population poses a serious challenge for the VA health service delivery system. While not all elderly veterans will turn to the VA for medical care, the demand for care is likely to increase with the number of aged veterans, reflecting not only their increased number but also the higher utilization rates associated with age. Demand for VA services could be even greater if other medical care programs, such as Medicare and Medicaid, are modified to decrease services or increase patient cost-sharing requirements.

The VA's greatest challenge may lie in providing adequate care for the veterans aged 75 and older. These persons consume the greatest amount of resources on a per capita basis. Currently, 21 percent of the Nation's aged veterans are between 75 and 84 years of age. By the year 2000, 3.45 million, or 38 percent of all aged veterans will be between the ages of 75 and 84.

## 2. THE SEARCH FOR APPROPRIATE LEVELS OF CARE

As the population in need of long-term care continues to grow, there is an increasing realization that alternatives to traditional long-term care institutionalization must be developed. Not only is the cost of institutionalization high, but institutionalization is not always appropriate to the need of the long-term care patient. Americans, by and large, are very supportive of finding lower cost, humane alternatives to institutionalization.

Alternatives to institutionalization are judged by two major criteria—cost-effectiveness and appropriateness of care. The growth of the elderly population, combined with rising expenditures for institutional long-term care services, has generated interest in strengthening community-based services for the sick and disabled and in altering the way in which these services are organized and financed. Studies have shown that community-based health and social services can be effective in reducing institutionalization and improving longevity and patient satisfaction. However, the overall costs associated with community-based long-term care remain unknown, as do the number of persons potentially in need of these services. In some cases, costs for this care may exceed amounts spent for the equivalent level of institutional care.

Public programs currently provide more financial support for institutional forms of long-term care than for community-based services. A great deal of attention has been focused on the need to target home and community-based services to those who would otherwise be institutionalized, but there appears to be little consensus on how the existing organization, delivery, and financing of long-term care services should be changed.

While 29 percent of the long-term care population resides in an institutional setting, 71 percent are in the community. Residents of institutions are generally more disabled than dependent elderly in the community, yet for every person 65 years of age and over residing in a nursing home, there are twice as many persons living in the community requiring similar levels of care.[12]

Informal care, primarily by family members, constitutes the bulk of care to the disabled elderly requiring assistance in activities of daily living. Formal sources of care (such as paid providers of home health, homemaker/chore services, adult day care programs) provide a minority of the care to the disabled elderly. In 1982, formal services accounted for less than 15 percent for all helper days of care in the community.

Clearly, alternatives to institutional care need to be more fully developed if we are to: (1) Afford care for all those who need it, and (2) provide care in the most appropriate—and often most preferred setting.

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[12] Health Care Financing Review, spring 1985, p. 70.

### (A) HOME HEALTH CARE

The issues of appropriate use and of cost-effectiveness of home health care are being considered by the Congress. While Congress has generally been supportive of the home health care benefit under the Medicare program, the administration has targeted this benefit for continued cutbacks. While evidence collected by the Senate Special Committee on Aging points out that many seniors need, but are denied access to home health care, the administration is concerned that the Medicare home health benefit may be overused and abused by beneficiaries and providers.

The cost-effectiveness argument for home health care has traditionally been based on the fact that it can cost considerably less to treat a subacute patient in his or her own home than it can in a hospital or nursing home. It is difficult to draw the conclusion, based on a one-to-one comparison of costs, however, that system or program wide costs will be lower through increased use of home health care.

The one-to-one comparison falls short of program application when the number of Medicare beneficiaries who genuinely need some form of home health care is considered. Congress, then, has been grappling with how to maintain the home health care benefit and how to make it more readily available to those in need, while still maintaining budget neutrality.

### (B) HOSPICE

The hospice benefit has now been a part of Medicare for nearly 3 years. When the benefit was established in 1983, it was given an expiration date of October 1, 1986. Thus, in 1985 Congress was faced with a choice either to extend the benefit (indefinitely or for a fixed period of time) or allow it to expire.

In addition to the need to reauthorize the hospice benefit, Congress also faced the unpleasant fact that a relatively small number of hospices had applied for and been granted Medicare eligibility. As of December 1985, only 220 hospices, out of 1,429 in the Nation, were participating in the Medicare Program. Two reasons are given by hospice administrators that are reluctant to join the Medicare Program: (1) The reimbursement levels are too low, and (2) there is uncertainty about the future of the benefit. To address these concerns, Congress was faced with the need to improve the daily reimbursement levels and to provide stability in the benefit by reauthorizing the program indefinitely. Both changes were eventually included in the budget reconciliation bill. (See legislative section.)

### (C) 2176 WAIVERS

To counter the institutional bias of Federal long-term care spending, Congress in 1981 enacted new authority for the Department of Health and Human Services (DHHS) to waive certain Medicaid requirements to allow States to broaden coverage for a range of community-based services and to receive Federal reimbursement for these services. Specifically, section 2176 of the Omnibus Budget Reconciliation Act of 1981 authorizes the Secretary of DHHS to approve "2176 waivers" for home and community-based services for individuals who, without such services, would require the level of care provided in a skilled nursing facility or intermediate care facility. Community-based services under the waiver may include case management, homemaker/home health aide services, personal care services, adult day care services, habilitation services, respite care, and other services. This new waiver option has been enthusiastically received by the States.

Beginning in 1984, however, several issues emerged which threaten to shut down the waiver option as an alternative to institutional care. First, several States have experienced lengthy delays in gaining approval for their waivers, which has hindered their State budget planning and implementation plans. Second, HCFA has asked some States to meet cost reduction targets which are not required by statute and has considerably tightened criteria for seeking waivers. By law, the cost of the waiver program may not exceed State Medicaid costs without the program, but cost savings were not mandated in the law. This fiscal squeeze has cast considerable doubt on whether States will still be able to provide adequate health care services to needy clients. Also some States have been required to include in their comparative cost calculations non-Medicaid Federal costs, such as AFDC, SSI, and food stamp payments.

These problems stem from a basic ambiguity about what Congress intended when the 2176 waiver option was enacted. Consequently, OMB has been able to emerge with greater control over the waiver process by focusing attention on the fiscal implications of the 2176 waiver program, rather than on the overall strategy of providing appropriate health and social services.

### (D) CHANNELING DEMONSTRATIONS

"Channeling" refers to organizational structures and operating systems created to ensure that long-term care services are received by a client. The concept is to control the demand for nursing home care by diverting persons to community-based services who would ordinarily be referred and admitted to institutions.

The National Channeling Demonstration Program, a DHHS initiative, is funded by the AOA and HCFA. Under this demonstration program, State and local agencies are to develop, coordinate, and manage long-term care services to be provided in the least restrictive environment and to be delivered without substantial amounts of new dollars. The core functions of the channeling concept are client assessment and care management. These functions should organize the care to meet an individual's specific needs and to control long-term care expenditures.

Early results from the channeling demonstration program do not prove the case that case management can ensure that the needs of the elderly population are better met at a cost-effective price. Instead, the early results show that case management did not reduce mortality rates, rates of institutionalization, or significantly reduce the amount of informal care already being received by elderly persons residing in their homes.

Quality of life factors, however, improved. For example, the level of unmet need seniors experienced was reduced and the general level of life satisfaction was improved. Informal caregivers also experienced an increase in life satisfaction, even while the level of care delivered by these caregivers did not fall. Nursing home costs and costs to families fell slightly, but costs overall rose slightly under the program.

Questions remain, however, about these early results. Many observers feel that the real savings of case management are realized in three ways: (1) Over extended periods of time, whereas these early results looked at case management over a 6-month period, (2) in areas that are not rich service areas, whereas the channeling project provided most care in rich service areas, and (3) for patients in the transfer period between hospital and home settings. For this third category, the channeling project did show significant savings, but only as a small snapshot from the total project.

### 3. FINANCING PROBLEMS

The financing issue is both the problem behind the long-term care population, and the impetus behind the search for alternatives to long-term care. Neither the Congress, the States, nor private constituencies have yet determined how to fully fund the long-term care needs of the future within the confines of current expenditure limits. Our choices include: (1) Changing our national priorities to allow us to shift funds from other programs and to the provision of long-term care, (2) increasing expenditures by increasing taxes, and (3) increasing private means of paying for long-term care.

#### (A) EXCESSIVE OUT-OF-POCKET COSTS

Many American families may want to care for chronically ill family members in their own homes. The Congressional Budget Office estimates that 10 to 40 percent of the 1.3 million people in nursing homes could live at home if they and their families received adequate assistance. But almost no financial assistance is now available to support them in their efforts.

Currently, reimbursement under Medicare and private health insurance is directed almost exclusively toward acute care or institutional care services. Because these programs do not provide adequate home health assistance for chronically ill individuals, families are responsible for almost all noninstitutional chronic care services.

In fact, the vast majority of the almost 4 million elderly afflicted with functional disabilities rely exclusively on informal support. Between 70 and 80 percent of these elderly persons living in the community who need long-term care receive all of the care they need from family and friends.

When, over time, families exhaust financial and emotional resources in caring for their chronically ill relative, the only Federal assisted option now available to them is institutional care—Medicaid financed nursing home care.

The ability of children to support disabled parents may diminish. As the population ages, very old chronically ill parents with children who themselves are retired or chronically impaired become more common. Researchers have noted that the probability of young elderly women (age 65-69) having at least one surviving parent aged 85 or older will more than double over the next 60 years. In addition, increased participation by women in the labor force is likely to decrease the amount of time they can spend on informal care of their relatives. Gerontologists have also noted that caretakers who have multiple roles—participation in the labor force and caretakers of children as well as disabled relatives—can experience tremendous levels of stress.

Clearly, we need to find ways to keep families involved in care of their older relatives for as long as and in as many cases as possible—without draining them of the ability to continue providing care.

One possible solution to the financing problem in long-term care is to provide families who care for elderly relatives with tax credits. These credits are a form of Federal financial aid to families to be used to help defray the cost of caring for an elderly relative in the home and to help pay for adult day care services, so the family can continue to provide in-home care, among other purposes.

The intent is to provide some Federal support for families who are struggling to care for elderly relatives in their own homes, thereby delaying what has come to be known as "family burnout," the point after which families are unable to continue to bear the enormous financial, emotional, and physical strain of maintaining the relative at home. Once the elderly person has to leave the home and enter a long-term care institution, the costs to the Federal Government can be significantly higher than the cost of supporting the family in providing home care.

### (B) STATE RESPONSES TO MEDICAID PROBLEMS

The fragmentation and lack of coordination among major Federal programs which support long-term care services have provided the States with major implementation challenges. The Medicaid, Social Services Block Grant, and Older Americans Act Programs all delegate administration and implementation responsibility to the States, and in so doing, require the States to deal with problems inherent in the different goals of these programs, as well as their varying eligibility requirements, service benefits, and reimbursement policies. These implementation problems have also resulted from the fact that fragmentation at the Federal level has been mirrored in State administration, with major long-term care programs being administered by different State agencies.

Many States have responded to these challenges by enacting legislation and/or creating initiatives to reorganize and restructure benefits offered through the Federal programs. Also, some States have consolidated the administration of various long-term care programs in a single State agency.

States initiatives to alter and coordinate their long-term care policies have been inspired, in part, by federally sponsored demonstration projects begun in the 1970's. For example, demonstrations funded under Medicaid and Medicare waiver authorities and the Older Americans Act research and demonstration authorities have served as models for State mandated case management systems and nursing home preadmission screening programs. Demonstration initiatives have also served as a testing ground for new community-based service models. For example, adult day care demonstrations which took place during the 1970's encouraged State and local agencies to merge existing health and social service funds available under Medicaid, title XX, and the Older Americans Act to create the now more than 1,000 adult day care programs in existence.

The objective of reducing institutional care costs and diverting potential users to other forms of care has been the impetus behind much of the State efforts to alter long-term care systems.

In nearly every State, Medicaid is already one of the top line item expenditures. In most States, anyone eligible for supplemental security income (SSI) is also eligible for Medicaid, and other State programs have extended Medicaid coverage to those whose incomes are somewhat above the SSI eligibility levels but are already institutionalized or have medical expenses that exceed their income.

States have tried to cut costs by instituting stricter reimbursement rules for nursing homes. Since 1980, when the Federal Government gave the States new leeway to determine how they would pay nursing homes under Medicaid, most States have switched from paying after the fact for whatever the nursing homes charged to setting daily fees that are often based on a nursing home's historical costs. Many of the States have used the new flexibility to increase rates for costs that are associated with direct care of patients while restricting reimbursement for nursing homes' capital costs and profit.[13]

Congress took no direct action on this difficult State issue, but seemed to acknowledge the increased burden the Federal Government has placed on States in recent years by exempting the Medicaid Program from cuts in the Gramm-Rudman-Hollings deficit reduction bill.

### (C) PATIENTS' RIGHTS AND QUALITY OF CARE IN LONG-TERM CARE INSTITUTIONS

While there is a severe shortage of nursing home beds nationwide, the problem has historically been greatest for patients needing skilled nursing care. Now that the large number of such heavier care patients are being discharged from hospitals, some communities, and some entire States, have an inadequate supply of skilled nursing facility beds. Medicaid eligible patients in need of skilled care are least likely of all patients to find the nursing home beds they need.

According to testimony heard before a hearing of the Senate Special Committee on Aging on October 1, 1984, this problem is due in part to State efforts to limit Medicaid expenditures by imposing a moratorium on new nursing home bed construction. A July 1985 survey of State Medicaid programs by the Intergovernmental Health Policy forum confirmed that four States have extended or initiated new nursing home bed moratoria.

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[13] National Journal, April 13, 1985, p. 799.

Federal reimbursement for nursing home care is irrational, disorganized, and bears no practical relationship to the needs of the patient. As a result, patients' access to quality nursing home care is often denied.

Legally, services provided in skilled nursing homes are covered under Medicare if they are for inpatients requiring skilled nursing care and related services, or patients who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Although the law provides for Medicare payments for up to 100 days of care in a skilled nursing home, Medicare seldom pays for more than half this number of days, about 28 days on the average. Moreover, although the law defines as covered those services requiring the supervision and observation of skilled nursing personnel, as well as physical therapy, HCFA's Medicare intermediaries deny reimbursement for patients needing physical therapy and skilled supervision so frequently that many providers have stopped billing the program for these services, even though the patient requires them.

When Medicare does not cover skilled nursing home care, patients must pay out of personal funds or must rely on Medicaid to finance their care. Not only is this hard on the patient financially, but it provides another disincentive for the nursing home to submit a bill to Medicare, because the nursing home can get people to pay a higher rate on a private pay basis than Medicare will pay.

Beneficiaries may appeal Medicare denials of skilled nursing care, but patients and their families are unaware of the rules governing Medicare eligibility and appeals until a sudden hospitalization and equally sudden discharge to the disorganized post-acute care continuum confront them with the harsh reality that Medicare pays for very little post-hospital care.

As a result, most patients don't know that a Medicare coverage denial can be appealed. If they do appeal, a patient or family may risk thousands of dollars each month on the services under contention, which must be provided in the interim. It can take a year or more to work up to the Administrative Law Judge (ALJ) level of appeal and actually get reimbursement.

In addition, very few beneficiaries know that in order to appeal a denial, a claim must first be submitted by the nursing home. Nursing homes have little incentive to do so, however, so claims are often not submitted to Medicare, thereby denying patients their right to appeal.

Even as patients are being forced by PPS to rely on nursing homes for sophisticated technical and professional nursing care, hundreds of these nursing homes are chronically and repeatedly failing to meet minimal Federal standards of care developed in the 1970's.

HCFA data, based upon thousands of nursing home inspections across the Nation, was analyzed by the DHHS Inspector General at the request of the chairman of the Senate Special Committee on Aging during late 1984 and early 1985. These data indicate that over 970 nursing homes in the U.S. have been chronically substandard for several years, yet HCFA still permits them to retain their Medicare/Medicaid certification and to continue admitting for care aged beneficiaries of these programs.

The issue at stake is in determining how to meet the needs of a sicker population in the post-hospital health care system.

As a result of its extensive investigation into this area, the Senate Special Committee on Aging developed legislative proposals to correct the problem of patients' rights and chronically substandard nursing homes. (See p. 207.) This legislation had not been introduced by the end of 1985.

#### (D) PRIVATE LONG-TERM CARE INSURANCE

The need for long-term care is the last uninsured event of the life cycle. Of total private spending for nursing home care in 1983—a total of $15 billion—only 1 percent was paid by private insurance coverage. Ninety-seven percent of the total private spending for nursing home care was paid directly by the consumer out of pocket. The average annual cost of nursing home care exceeds $20,000 per year, representing a catastrophic expenditure beyond the financial reach of most elderly.

Most of the 12 to 20 long-term care insurance plans on the market provide very limited benefits—covering only post-hospital convalescent illnesses. Coverage for chronic long-term care nursing home patients has yet to be made available.

While at least four major insurers are beginning to develop and market long-term care insurance policies, many issues still need to be worked out before long-term care insurance will become a viable coverage mechanism for catastrophic chronic conditions. Even when these policies become available, many people are still very concerned that long-term care insurance will provide coverage only for wealthy and healthy seniors.

A critical issue in making long-term care insurance a viable option for older Americans is the fact that many seniors still believe that the Medicare Program provides coverage for long-term care. Beyond that, Medicaid is also viewed by many as a national coverage program for long-term care, even though it is meant to be a low-income medical assistance program.

Nontraditional health insurance alternatives have also been advanced as viable options for long-term care financing. Some have suggested that long-term care services can be controlled only in a managed care system, such as an Health Maintenance Organization (HMO). The "social HMO" demonstration project will provide information about the feasibility of this approach. In addition, some have pointed to tax preferred case accumulation plans, such as individual retirement accounts (IRA's) reserved for long-term care costs, as possible approaches to be considered.

## C. LEGISLATION AND REGULATION

Consistent with other issues in aging, congressional and administrative action in long-term care was largely driven by budget considerations. Within these constraints, however, several positive initiatives were developed in Congress to address the growing demand for long-term care, the search for more appropriate forms of care, and the financing problems faced by millions of chronically ill older Americans and their families. Most of these initiatives have yet to be enacted because they were included in the Consolidated Omnibus Budget Reconciliation Act (COBRA—H.R. 3128), which is stalled in conference as of this writing. Nonetheless, most provisions should be enacted in the near future, since nearly all were approved by both Houses of Congress.

### 1. WAIVER OF LIABILITY

Nursing home and home health providers are nearly unanimous in their support of the waiver of liability as a necessary tool to assure access to care, especially for the new subacute patients created by the prospective payment system (see p. 244). Nonetheless, on February 12, 1985, the Health Care Financing Administration published a proposed rule in the Federal Register to eliminate the current waiver of liability for all Medicare providers. Under this rule, waiver of liability would be established on a case-by-case basis and would not be granted unless the provider could prove the inability to reasonably know the particular coverage rules in question.

Congress was concerned that reasonable knowledge of coverage rules could not be assumed for two reasons: First, because there were significant variations among the fiscal intermediaries in interpreting coverage guidelines and second, because much of the communication between the fiscal intermediaries and the providers was not sufficient for the providers to distinguish why one case might be covered but not another. As a result of this concern, two provisions were included in the 1985 Consolidated Omnibus Budget Reconciliation Act which would retain the waivers of liability for skilled nursing facilities and home health agencies.

### 2. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES

Congress, this year, attempted to find at least a partial solution to the problem of reimbursement uncertainty by proposing a prospective payment system for certain skilled nursing facilities. Congress, the provider community, and senior advocates generally agree that a prospective payment system for skilled nursing care would increase providers' willingness to accept Medicare patients. It is assumed that a prospective payment system would give providers more certainty in payment and possibly a more attractive payment rate than they are now receiving. A prospective payment system for nursing home care is yet to be fully developed, but Congress, in the Consolidated Omnibus Budget Reconciliation Act of 1985, took interim steps toward this goal.

Congress' action was targeted at nursing home providers who participate only to a very limited extent in the Medicare Program at present. These providers accept few Medicare patients and provide fewer than 1,500 Medicare patient days of care a year. Congress tried to increase this participation rate in four ways:

First, Congress agreed to pay these providers a limited prospective payment rate of 105 percent of the mean for routine Medicare SNF costs, affording reluctant providers a known, attractive payment rate to care for Medicare patients. Second, Congress increased these providers' incentives to accept Medicare patients by requiring them only to file minimal cost reports, thereby lightening the paperwork burden. Third, to improve the evenness of administration of the benefit, the Secretary of DHHS would be required to reduce the number of fiscal intermediaries to 10 within 18 months of enactment and strengthen monitoring of the administration of the SNF benefit. And fourth, the waiver of liability presumption would be maintained for SNF providers for 30 months after enactment and for home health agencies for 12 months after the consolidated fiscal intermediaries begin operation.

Prospective payment for certain SNF's was included in COBRA, which at the time of this writing, has not been enacted into law.

### 3. VETERANS HEALTH AND LONG-TERM CARE

If elderly veterans request and receive care at the current utilization rates, the real costs of providing veterans' health care could double within the next decade. In order to deal with the rising costs of care for this subgroup of the veteran population, Congress took up H.R. 505, originally introduced as the "Older Veterans Health Care Act of 1985." Though the bill underwent substantial modifications in the House and the Senate to add provisions concerning other VA user groups, the final version of the bill as signed by the President contains two provisions specifically aimed at dealing with the increasing demands made on the VA health care system by older veterans. First, the act allows veterans who are discharged from VA nursing homes and domiciliaries to receive outpatient care in order to complete their medical treatment. Under prior law, only those veterans discharged from VA hospitals were eligible for the VA outpatient care needed to complete medical treatment.

The second provision allows non-service-connected disabled veterans in VA nursing homes, domiciliaries, and hospital-based home care programs to be admitted directly to community nursing homes at VA expense. Under prior law, such veterans could be admitted to community nursing homes only from VA hospitals.

Each of these provisions is valuable in that it promotes the most effective utilization of scarce VA health-care resources. This is done by eliminating the incentive to arrange medically unnecessary hospital admissions in order to spare veterans the cost of paying for care in less expensive community nursing homes or outpatient settings out of their own pockets.

*Means test.*—A number of other legislative changes were proposed in 1985 to affect older veterans. The most controversial was an administration proposal to apply a means test to the VA health care program for the purposes of determining eligibility and collecting third party reimbursement from private insurers for the care given to non-service-connected disabled veterans.

Under current law, the VA health care system serves veterans without a service-connected disability to the extent that its resources allow (that is, it is not an entitlement program). Veterans 65 and over are eligible for this care regardless of their income. Veterans under 65 years of age are asked simply to take an oath that they "are not financially able to defray the costs of care elsewhere."

The administration's fiscal year 1986 budget proposals, however, and the 1985 deficit reduction package both added a means test to replace this oath of financial inability to pay. This test would apply to all veterans, regardless of age.

This proposal stirred much controversy when it was first introduced. Concern was raised about whether a means test would have a detrimental effect on the ability of veterans to gain access to health care. Individual veterans and their organizations voiced fears that many who now depend on the VA for health care would be forced under a means test to nearly bankrupt themselves before they could receive VA care. Members of Congress also were concerned that a means test would not lower health care costs overall, but would simply move some of the expenses from VA health care programs to the Medicare and Medicaid programs.

Although modified to be less stringent than that originally proposed by the administration, a means test was included in the deficit reduction bill for 1985, which was passed separately by both Houses of Congress but as of this printing it had not yet been conferenced and sent to the President for signature. The same concept has been proposed once again by the administration in its fiscal year 1987 budget.

*Long-term care for veterans.*—Chairman Heinz of the Aging Committee introduced his own bill to help older veterans get the most appropriate, comfortable, and cost-effective health care in the most appropriate setting. That bill, S. 1422, "The Elderly Veterans' Care Act of 1985," is predicated on the idea that family-provided care in the home is preferable, both on a personal as well as an economic level, to long-term institutional care. "The Elderly Veterans' Care Act," which was also introduced in the House by Representative Ridge, would provide a tax credit for the home health care expenses a veteran and his or her family must face in order to provide proper, home-based care. The credit would be available to veterans over age 65 who face chronic illness and is targeted toward lower income families. Specifically covered are home health aides, adult day care, respite care, nursing care, and medical or health-related equipment and supplies.

The bill was designed to encourage an independent living environment for elderly veterans. It does not require financial dependency but instead allows the veteran to live where he pleases. In this way, the bill complements the VA's hospital-based home care program which was recently established to serve veterans in the setting they prefer—their home—and to help them avoid expensive institutionalization. No action had been taken on this bill at the time this document went to print.

### 4. HOME CARE FOR VENTILATOR-DEPENDENT PATIENTS

This year, Congress considered the problems of ventilator-dependent Medicaid and Medicare patients. Many of these patients are not being served in the most appropriate long-term care setting because of out-dated and overly restrictive regulations. Whereas many of these patients are medically able to go home or to a skilled nursing facility, they are confined to hospitals since Medicare and Medicaid regulations will only pay for the cost of care in a hospital setting.

Senator Heinz introduced legislation, S. 1249, a portion of which was included in the deficit reduction bill (COBRA) under which Medicaid patients who are dependent on a ventilator at least 6 hours a day, and have been so dependent for at least 30 consecutive days, would be eligible for Medicaid-reimbursed ventilator care in the home setting. Currently, these patients are eligible for Medicaid-reimbursed ventilator care only while it is provided in a hospital.

This provision, which the Congressional Budget Office estimates will save the Federal Medicaid Program $2 million in 3 years, is included in COBRA, awaiting further congressional action.

### 5. HOME HEALTH REIMBURSEMENT

A second problem in home health care was addressed as well. In the past, home health agencies were reimbursed under the Medicare Program for their reasonable costs, not exceeding the 75th percentile of aggregate agency costs. On July 5, 1985, HCFA published final rules effective July 1, 1985, which altered the way in which home health cost limits are calculated. Under the new rule, home health agencies are reimbursed at 120 percent of the mean of visit costs and are not permitted to aggregate these costs. The regulations also call for an automatic reduction to 115 and 112 percent of the mean in the 2 subsequent years respectively.

Many home health care and senior advocates felt that these restrictions would significantly reduce the amount of Medicare home health benefits available to those in need at a time when the need for these services is sharply increasing. As the Senate Special Committee on Aging demonstrated, the enactment of the prospective payment system for hospital care created a significant increase in the need for post-hospital care, including home health care.

As a result, legislation was introduced in the Senate, S. 1450, by Senator Heinz and Senator Glenn, and the House, H.R. 3202, by Congresswoman Roukema, to impose a 1-year moratorium on implementation of the new rule. As a result of this legislative action, a provision was included in the 1985 Consolidated Omnibus Budget Reconciliation Act which would require the Secretary of the Department of Health and Human Services to allow home health agencies to aggregate costs and to conduct a study of the effects of disaggregation and the cost limits on home health agencies and beneficiaries. The study is to be sent to Congress no later than September 1, 1986.

### 6. HOSPICE

Congress also voiced its support of hospice as an appropriate long term care alternative for terminally ill cancer patients by including three important hospice provisions in COBRA. Under current law, the Medicare hospice benefit is scheduled to be sunset on October 1, 1986. The Medicare hospice benefit has also been recognized as being drastically underreimbursed. At Senator Heinz' initiative, the sunset provision for the Medicare hospice benefit would be eliminated, and the Medicare hospice reimbursement rate would be increased by $10 per day. In addition, the hospice benefit under Medicaid would become a permanent State option. As with all COBRA provisions, these are yet to be passed by the Congress or signed into law.

### 7. 2176 WAIVER

Given the enthusiastic response with which States, patients, and their families have greeted the waiver programs, and given the great need to develop alternatives to institutionalization, Congress has been forced into action in 1985 to ensure that the 2176 waiver option will continue to be available.

Congress generally is very supportive of the 2176 waiver program. With this support, Senator Bradley was successful in gaining inclusion of three important waiver provisions in the 1985 Consolidated Omnibus Budget Reconciliation Act, which is yet to pass the Congress. The intent of these provisions is to help prove the benefit of the waiver programs and help make it easier for States to continue operating their waiver programs.

The first provision will establish a demonstration program for home and community based care. Under this program, the Federal Government will conduct demonstrations in four States to determine whether and to what extent State controlled home and community-based services programs for elderly, disabled, and developmentally disabled Medicaid recipients reduce expenditures for society as a whole, for the Federal Government, and/or for States.

Two other Bradley provisions would extend the section 2176 home and community based waiver from a 3 to a 4-year waiver and would prohibit terminations of any waivers for 1 year from the date of enactment of the bill.

Senator Bradley, with Senators Glenn and Chiles, also introduced S. 1277, the Medicaid Home and Community Based Waiver Improvement Act, which would redesignate waivered services as optional services under a State's Medicaid plan, effectively removing the home and community-based programs from the waiver process. This bill has not been acted on by the Congress.

### 8. TAX CREDITS FOR FAMILIES CARING FOR ELDERLY

One mechanism for addressing the growing financial burden on families who provide long-term care services for older relatives is some form of tax credit. A number of bills were introduced in the 99th Congress to provide tax credits for families who care for their elderly relatives in their own homes. Among these bills was S. 779, the Family Care Act, sponsored by Senator Heinz. S. 779 would provide tax credits for a portion of expenses incurred for the support services that the chronically ill elderly and their families most need—home health aide services, adult day care, respite care, nursing care, and medical or health-related equipment and supplies. The bill is targeted to provide the greatest relief to those families most in need. The amount of credit will be determined on a sliding scale based on annual income. The sliding scale is based on the same formula as the dependent care tax credit adopted by Congress as part of the Economic Recovery Tax Act of 1981.

S. 779 and other bills like it have not received serious congressional attention, primarily because Congress seems to be more interested in dollars saved today than dollars spent today to save many times that amount in the future.

### 9. Private Long-Term Care Insurance

In order to stimulate the growth and development of private long-term care insurance policies, legislation was introduced this year by Congressman Ron Wyden and Senator David Durenberger, H.R. 2293 and S. 1378, which would establish a long-term care task force for the purpose of establishing recommendations for long-term care insurance policies.

This legislation was included in COBRA in modified form. As agreed to by House and Senate conferees, the provision will require the Secretary of the Department of Health and Human Services to establish, in consultation with the National Association of Insurance Commissioners, an 18 member Task Force on Long-Term Health Care Policies. This task force will develop recommendations for long-term care policies, and report to the Secretary and to Congress within 18 months after its creation.

The report is to be distributed to the States for their voluntary use when considering whether to approve long-term care insurance policies to be marketed within the States. The legislation in which this provision is included has yet to be passed by the Congress or signed into law.

## D. PROGNOSIS

Barring an extraordinary and unanticipated surge of public interest, congressional action on long-term care is not likely in the near future. Issues may well be discussed, but any legislation is likely to narrowly focus on proposals to improve cost-effectiveness.

Congress seems to be most interested in ensuring that patients who need long-term care services have access to those covered benefits and that the quality of care in these long-term care settings is high. Efforts to largely rewrite the long-term care system, however, are very unlikely. The atmosphere in Congress seems to be more one of preserving existing health care benefits and ensuring access to that care than expanding long-term care coverage.

On the private side, private long-term care insurance seems to be developing into a more viable alternative than may have been thought in the past. Congress will, no doubt, be taking a close look at private long-term care insurance as a possible funding alternative to meet the needs of the future.

# Part IV

# HOUSING

As the proportion of older persons, particularly frail elderly, increases, and housing and energy expenses escalate, Congress and the administration have set out to drastically reduce the Federal housing commitment. At the beginning of 1985, the President proposed ending construction of new units as part of the fiscal year 1986 budget proposal. By the end of 1985, the enactment of the Balanced Budget and Emergency Deficit Control Act, commonly called the Gramm-Rudman-Hollings Act, inaugurated a process of automatic spending cuts to achieve specified deficit reductions targets which threatened to devastate housing and energy assistance programs further.

The need for elderly housing continues to increase. A growing elderly population is one factor. Current demographic projections indicate that the number of households headed by older persons is rising steadily. More than one-fifth of all U.S. households—approximately 17 million—are headed by persons 65 years of age or older. Seven million are headed by persons over 75.[1] From 1980 to 1995, the percentage of households headed by persons over 65 will rise by 33 percent, and those headed by persons over 75 will increase 52 percent. In 1995, 21.4 million households will be headed by Americans over 65.

In addition, there is a growing need for special living arrangements and support services for older persons. An increasing number of frail elderly—those over 75 years of age with mild to moderate impairments in their activities of daily living—are aging in place in Federal housing projects and in private residences. This stark fact raises serious questions on ways to best provide a supportive environment where social, physical, and emotional needs are met without jeopardizing the independence of older Americans.

Rapidly escalating housing costs have contributed to the need for Federal programs. This problem is expected to continue as the number of older Americans increases and the cost of housing rises in relation to other living expenses. Housing costs for the elderly are being driven up by taxes, rising utility bills, higher home repair costs, and insurance, as well as rent hikes and condominium conversions. The result is a serious lack of affordable and safe shelter for a large number of older Americans. The problems is particularly acute for renters, who pay a far larger share of their incomes for housing than homeowners. Recent data indicate, for example, that an elderly woman living alone spends nearly 50 percent of her income on housing. Some 2.3 million elderly households spend over 35 percent of their incomes on housing.

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[1] U.S. Bureau of Census Population Survey; unpublished data.

The majority of the elderly have equity in their homes that could help in meeting their housing costs. Three out of every four elderly persons own their own homes; 80 percent of them, mortgage free. These are often elderly suburban homeowners with low incomes and few significant liquid assets. These factors have contributed to the growing interest in innovative housing arrangments, such as home equity conversion plans, and in strategies for allowing the "overhoused" elderly homeowner to take advantage of more appropriate, maintenance-free housing through such alternatives as life-care communities.

In addition to increased housing costs, dramatic rises in the cost of home energy have been particularly devastating to the elderly, who consume relatively less energy than other households, but pay a larger portion of their disposable income for fuel. Expenditures for home energy among low-income groups have increased since 1985 by over 47 percent on average. The rise in energy costs in relation to income, as well as legislation associated with the crude oil windfall profits tax have been the impetus behind congressional enactment of several energy assistance programs, designed to help low-income individuals with a special emphasis directed toward the elderly. Since the late 1970's these assistance programs have grown both in size and scope.

Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit have made these programs principal targets for budget savings.

# Chapter 9

# HOUSING PROGRAMS

## OVERVIEW

Housing and shelter needs of the elderly have been a primary concern in the area of aging social policy for a number of years, and during the last two decades the Federal Government has substantially increased its response to this concern. The question today is: Has this response reached its peak?

The future of Federal housing assistance depends greatly on the actions Congress will take in calendar year 1986 with regard to the Gramm-Rudman-Hollings amendment to the debt limit, reconciliation, and the fiscal year 1987 budget. Although similar statements could be made most years, the important difference now is the fact that Congress has finally addressed the issue of our mounting national debt in an aggressive manner by mandating action by others in a manner that, unless redirected, will definitely reduce the amount of housing assistance the Federal Government provides.

During 1985, the administration and Congress did little to advance the cause of providing housing to the Nation's elderly, handicapped and poor. In fact, the administration attempted through its fiscal year 1986 budget proposal to place a 2-year moratorium on virtually all new construction, and to drastically limit other modernizing and operating expenses. Congress, on the other hand, had little success changing the course of current housing programs. An appropriations bill was signed into law which continued most HUD programs at fiscal year 1985 levels with some modest increases. The House passed an authorization bill as part of reconciliation, but hopes for any authorization prior to December adjournment fell through when reconciliation legislation negotiations broke down.

## A. FEDERAL HOUSING PROGRAMS

### 1. Background

Beginning in the 1930's with the low-rent public housing program, the Federal role in housing for low- and moderate-income households has expanded significantly. In 1949, Congress adopted a national housing policy calling for a decent home and suitable living environment for every American family. The Federal Government has developed a variety of tools and programs in an effort to achieve this goal. One approach has been to provide housing directly through new construction programs and rental assistance payments which are aimed at providing adequate and affordable housing for those who could not otherwise afford it. A second and more costly approach has been to provide tax incentives for house construction and homeownership through deduction of mortgage interest and property tax payments from individual gross income and through a variety of tax provisions favoring real estate transactions.

Heightened concern with old age housing issues had its origins in 1950 when the first National Conference on Aging recommended greater Federal emphasis on the housing needs of older persons. It took almost 10 years, however, for enactment of legislation targeting the elderly as beneficiaries for housing assistance.

Although low-income public housing, created under the Housing Act of 1937, was not initially intended to provide special assistance for the elderly, it began to evolve into one of the principal forms of Federal assistance for low-income older persons in the late 1950's. Prior to 1956, only 10 percent of all the public housing units were occupied by persons 65 years and older. Between 1956 and 1959, however, several legislative changes were made to encourage construction of units for the elderly. As a result, the percentage of public housing units occupied by the elderly increased to 19 percent in 1964 and to 46 percent in 1984. In addition, 1959 saw the enactment of the section 202 program, the first housing program specifically designed for the elderly.

In the mid-1970's, Congress expanded Federal housing assistance to the elderly significantly. The section 202 elderly housing program was reinstated after being phased out in the late 1960's and the section 8 housing assistance program was enacted which, although not specifically targeted to the elderly, has become one of the two major sources of assisted housing units occupied by those 65 years of age and over. Today, section 8 provides approximately 800,000 units of assisted housing for the elderly. Another major source, public housing, provides roughly 650,000 units for elderly families. Section 202, traditionally thought of as the elderly housing program, has provided less than 150,000 apartment units for elderly families.

### (A) SECTION 202

The section 202 program is the primary Federal financing vehicle for constructing subsidized rental housing for elderly persons. Under the section 202 program, the Federal Government makes direct loans to private, nonprofit sponsors for use in developing section 8 housing designed specifically to meet the needs of the low-income elderly and the handicapped. Since the program's authorization in 1959, over 147,000 units have been constructed.

The original section 202 program operated from 1959 to 1969, when it was phased out in favor of other programs. During this 10-year period, the program provided construction financing and 50-year permanent loans at 3 percent interest to nonprofit and limited dividend sponsors of housing for low- and moderate-income elderly and handicapped persons. Approximately 45,000 units were constructed.

Under the revised section 202 program, authorized in 1974, loans to sponsors were made at a rate based on the average interest rate of all interest-bearing obligations of the United States forming a part of the public debt, plus an amount to cover administrative costs. The 202 loan rate was fixed at 9¼ percent in 1983, in response to rising interest rates, and it has remained fixed at this rate since.

The original section 202 program was successful. Only one project was foreclosed in a 10-year period. The program served basically middle-income rather than low-income elderly during this time. Since the revised program is used in conjunction with the section 8 program (HUD's major vehicle for the provision of housing to low-income households), it serves a wider range of elderly households.

Under the revised section 202 program, funds are allocated on a geographic basis for metropolitan and nonmetropolitan areas among the 10 HUD regions, taking into account the number of elderly households within each region, those households lacking some or all plumbing facilities, and those with incomes below regionally adjusted poverty levels. In 1983, there were approximately 4.7 million elderly rental households representing about 26 percent of all elderly headed households in the United States.

The Department of Housing and Urban Development—Independent Agencies Appropriations Act of 1986 [Public Law 99-160] appropriated $631 million of direct loan obligations to be made under the section 202 program. This amount is intended to provide funding for the construction of approximately 12,000 section 202 units, about the same number as built in 1985.

A large percentage of new construction of housing over the past 10 years has been for the elderly. The relative lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities there is a long waiting list for admission to projects serving the elderly. Such lists can be expected to increase as the demand for elderly rental housing continues to increase in many parts of the Nation.

A review of the HUD section 202 elderly housing program, requested by Senator John Heinz, and completed by the General Accounting Office (GAO) in December 1985, provided some basic information on how the program is actually being utilized. Nearly all of the program beneficiaries were single. Beneficiaries on average were 73 years old, were white, had lived in their unit/project for about 2.5 years, and had an annual income of about $6,600. Most (82 percent) had very low incomes—below 50 percent of the median income (adjusted for household size) for the areas in which they lived.[2]

Most beneficiaries lived in a one-bedroom unit that rented on average for $480 a month and contributed about $146 toward this rent. The balance of $334 was paid by the Government through section 8 rental assistance payments.

GAO found that in the survey sample the housing needs of minority elderly are not being met by the 202 program. Minority elderly are on average poorer than white elderly, yet most projects have few, if any, minorities. Of the 142 projects sampled, (1) 42 percent of the projects, which accounted for about 33 percent of program beneficiaries, had no minority tenants, and (2) 70 percent of the projects, with 68 percent of the tenants, had 5 percent or less minority tenants. For the most part, minorities were concentrated in a few projects. Sixty percent of the minorities in the sample were housed in 13, or 9 percent of the projects sampled. At each of the 13 projects, more than 50 percent of the tenants were minorities.

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[2] The analysis conducted by GAO is based on a review of HUD records for 179 projects at 10 HUD field offices, visits to 47 of these projects, and data on 802 section 202 projects, obtained from HUD's Computer Underwriting and Processing System. The study was limited to projects primarily serving the elderly.

### (B) PUBLIC HOUSING

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing for the families of unemployed blue-collar workers, the Nation's Public Housing Program has burgeoned into a system that includes 1.2 million units housing more than 3.5 million people. In fiscal year 1985, the program cost the Federal Government more than $4.8 billion for operating subsidies, construction debts, and major repairs.

The Low-Rent Public Housing Program is the oldest of those Federal programs providing housing for the elderly. Over 43 percent, or approximately 514,000 units, of the Nation's more than 1.2 million public housing units are occupied by older Americans. It is a federally financed program which is operated by locally established, nonprofit Public Housing Authorities (PHA's). Each agency usually owns it own projects. By law, the PHA's can acquire or lease any real property appropriate for low-income housing. They also are authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects.

Federal assistance to the public housing projects is in the form of annual contributions that are used to pay the PHA's debt service. Originally this was the only form of Federal public housing assistance. It was assumed that tenant rents, originally set at amounts no higher than 25 percent of a tenant's net income (now raised to 30 percent), would cover project operating costs for such items as management, maintenance, and utilities. Over the past few years, tenant rents have not kept pace with increased operating expenses. Recent changes requiring greater targeting of benefits to the very low income group (50 percent of area median rather than 80 percent) also decrease rental revenues for the public housing authorities. As a result, Congress has provided additional assistance to the projects to cover these expenses. Annual operating subsidies totaled 1.2 billion in fiscal year 1985.

Much of the public housing was built three and four decades ago and is in need of major renovation. Even its staunchest supporters admit that the program has been plagued by mismanagement in some cities, often aggravated by local political interference and patronage. And, it is a system that has become home for many chronically unemployed and underemployed people who can ill-afford to pay significantly more in rents to offset the skyrocketing cost of operations and maintenance.

About half of all the units in assisted projects were developed under and continue to be operated within the public housing program. It has been by far the largest program for the production of housing for low-income families. In recent years, substantial dissatisfaction with the program has been voiced from several quarters: By Congress about the condition of the projects and their management; by public housing authorities [PHA's] about their rising costs and the inadequate funding levels for modernization; and by the Office of Management and Budget [OMB] about ever-burgeoning outlays. Additionally, the managers of the public housing projects continue to raise their concern about the lack of congregate services for their tenants who have aged-in-place and are in need of supportive services in order to remain independent.

### (C) SECTION 8

### *(1) Construction/Existing*

The section 8 program was created in 1974 to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Under the program, HUD enters into assistance contracts with owners of existing housing or developers of new or substantially rehabilitated housing for a specified number of units to be leased by households meeting Federal eligibility standards. Payments made to owners and developers under assistance contracts are used to make up the difference between what the rental household can afford to pay for rent, and what HUD has determined to be the fair market rent for the dwelling. As of the end of fiscal year 1985, there were 2.4 million units reserved under the program, of which about 2 million are completed or, in the case of existing housing, ready for tenant certification by a public housing agency. Of those units, it was estimated by HUD that approximately 40 percent are occupied by older persons.

The concern over the Federal deficit has forced the Federal Government to reassess the cost effectiveness of many social programs, including the new housing construction programs. Section 8 was not designed originally to provide any form of direct subsidy to project sponsors in meeting their costs of construction and financing, but was structured to stimulate construction by guaranteeing that low-income occupants would be subsidized through rental assistance programs, thereby assuring occupancy—and rental income—for the developed units.

Shortly after the start of the program, developers found that they had difficulty in keeping their rents below those established by HUD's fair market rents, largely because of the high mortgage rates prevailing in the late 1970's. Consequently, effective rates were lowered for most projects, either by the Government National Mortgage Association's [GNMA] purchase of mortgages under its special function, or by financing from State housing financing agencies or from public housing agenices, both of which obtained funds from sale of tax-exempt bonds. GNMA exhausted its available funds, and it became evident in 1981 that increased rates in the tax-exempt market were threatening to halt assisted housing production. By the end of 1982, limited additional assistance had been provided to projects financed through State housing finance agencies by means of the finance adjustment factors [FAF], which in effect raised permissible rents over the fair market rent level. The relatively high subsidy cost arising from both the high rent supplement required to cover construction costs and the additional indirect subsidy to lower interest rates caused increasing concern in the administration and Congress. Finally, in the Housing Act of 1983, the section 8 new construction program was repealed except for that attached to the section 202 program.

While the production component of the section 8 program has been viewed as unsuccessful, the existing housing component of the section 8 program has generally been alluded to as a successful form of assistance. Under the section 8 existing housing program, HUD pays the difference between 30 percent of an assisted housing tenant's income and the fair market rent standard for the jurisdiction.

### *(2) Vouchers*

The Housing Act of 1983 continued section 8 existing certificates but also established a section 8(o) demonstration voucher program. Use of the 15,000 vouchers authorized by the act was limited primarily to HUD's new rental rehabilitation program, the FMHA Rental Preservation Grant Program. However, 5,000 units were allocated to a "free-standing" program to provide an opportunity to compare the operation of the voucher program with the section 8 existing certificate program. The Department of Housing and Urban Development—Independent Agencies Appropriations Act of 1985 [Public Law 98–371] added funding for another 42,000 vouchers. Under the voucher system, also referred to originally as the modified section 8 existing housing certificate, HUD's contribution is also based on the difference between an established rent payment standard for each market and 30 percent of a new tenant's income. Like fair market rents, the rent standard is set at the 45th percentile of the distribution of rents of standard quality in newly occupied units, and tenant eligibility is based on an income standard of 50 percent of area median income.

The tenant, however, will pay more or less than 30 percent of his income for rent. HUD's contribution is still based on a 30-percent-of-income contribution, but the rent standard is not necessarily the actual, or maximum, rent. Rather, the rent received by the landlord is based on whatever is negotiated between the tenant and landlord, as in the private market. Thus, if a tenant finds a unit which is cheaper than HUD's rent standard, that tenant would be able to keep some of the subsidy for other uses. Conversely, if a tenant rents a unit which is more costly than the rent standard HUD uses, that tenant would have to contribute more than 30 percent of income to make up the rent payment. Another difference between the two programs is the duration of the assistance contract which is limited to 5 years under the voucher program compared to the 15-year duration of the section 8 existing housing contracts. The HUD appropriations act for 1985 provides $500,000 for HUD's research budget to evaluate vouchers versus 5- and 15-year section 8 contracts. This evaluation has not been completed.

### *(3) Rental Rehabilitation and Development*

New rental rehabilitation and production programs were enacted under title I of the Housing and Urban-Rural Recovery Act of 1983 [Public Law 98-181]. The programs authorize Federal commitments of just 5 years (much shorter than the 15- or 20-year commitments under section 8), greater requirements for local public and private sector investments in the projects, stricter limits on Federal per unit costs, and greater demonstration of rental housing need by local authorities. Interim regulations governing the rehabilitation portion of the program were issued on April 20, 1984, while regulations governing the production segment of the program were published on June 14, 1984.

The rental rehabilitation program, authorized at a level of $300 million for fiscal years 1984 and 1985, is formula driven and allocates funds directly to selected cities with populations of 50,000 or more, urban counties, and States for distribution to smaller communities. The program is targeted to low- and moderate-income families. The first grants under the program, which totaled $14.2 million, were awarded to 76 cities and urban counties and one State in August 1984. Grantee communities will get housing vouchers or section 8 certificates to assist lower income families to remain in their unit after rehabilitation activities are completed or to relocate to other suitable housing.

According to HUD's second annual report, $144 million of commitments to grantees had been made through June 30, 1985, and by the end of July, work was under way on 2,247 projects with 16,424 units. However, the fiscal year 1986 appropriations bill [Public Law 99-160] cut the program's annual budget from $150 million to $75 million. The Rental Housing Development Program, authorized at a level of $200 million and $115 million for fiscal years 1984 and 1985 respectively, is run on a competitive basis and is targeted toward low- and moderate-income families as rental rehabilitation grants. Implementation of this program was delayed by the controversy over the size and composition of cities eligible to compete for grants. On June 20, 1984, HUD published in the Federal Register a list of areas designated as eligible for program assistance. On October 23, 1984, HUD announced the awarding of $288 million to 141 projects. It is estimated that these awards will assist in the construction of 14,462 units. Fiscal year 1986 appropriations were cut to $75 million.

The $150 million authorized for these two programs for fiscal year 1986 is very modest compared to the costs of section 8 new construction/substantial rehabilitation programs which they are designed to replace. The latter, for instance, were allocated more than $10 billion in new budget authority in fiscal year 1981.

### (D) TAX PROVISIONS

The principal tax provisions promoting homeownership and the production of housing in this country include: Homeownership tax subsidies, rental housing investment subsidies, and tax-exempt mortgage revenue bonds. Of principal interest to elderly Americans are: The one-time exemption from taxes of up to $125,000 in capital gains for those over 55; and multifamily rental production incentives provided in the Tax Code and through mortgage revenue bonds.

Given current high interest rates, there would be very little construction of multifamily rental housing without tax provisions such as accelerated depreciation; amortization of construction-period property tax and interest expenses; low-income rental housing rehabilitation and historic preservation tax credits; and the sale of tax-exempt bonds. Even so, these incentives tend to lead to the production of housing for renters in the moderate and upper income brackets, rather than for the poor. Low-income projects are more risky, are less profitable, and attract fewer investors. For this reason, tax-exempt bonds for multifamily mortgages have been statutorily limited to projects with at least 20 percent of their units occupied by low-income renters.

## 2. Issues

### (A) LIMITING THE FEDERAL ROLE

Since its inception, housing policy in America has focused almost exclusively on the provision of standard units of low- and moderate-income housing for eligible individuals and families. This approach has been inadequate in that the Federal Government has been unwilling to treat housing assistance as an entitlement, and, as such, many eligible households simply cannot find the assistance they need. Data indicates that the total of over 4 million assisted units projected to be available by the end of fiscal year 1985 are enough for, at best, 25 percent of those eligible for assistance.

Approximately 1.5 million units assisted under Federal housing subsidy programs are occupied by elderly households. Recent figures on the numbers of elderly households eligible for assistance, those below the 50 percent of median income, indicate that an additional 2 million eligible families are not served by the Federal programs. A substantial number of these families may own their own homes, and although very poor, would not benefit from the subsidy programs designated for low-income renters.

Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit have made these programs targets for budget savings. The net effect of these fiscal constraints has resulted in a policy shift by the current administration toward other approaches for meeting the housing needs of older persons. The current administration's program for housing and community development has sought to limit the role of the Federal Government in housing assistance. The main thrusts of the administration's housing assistance policies have been to shrink the growth of the program and to seek less expensive solutions. Since 1981, it has attempted to contain the budgetary growth of housing programs by targeting assistance to those most in need, and relying almost exclusively on direct assistance to households in existing units.

Proposals including program cuts or elimination, targeting and tenant rent contribution increases, housing vouchers, block grants, cost containment, and greater reliance on the private sector for innovative approaches, and alternative housing options have been advocated.

A housing authorization bill has not been sent to the President since 1983 when, responding to the administration's policies and concerns over continued high Federal budget deficits, Congress enacted the Housing Act of 1983 [Public Law 98-181]. This legislation eliminated authorizations for the section 8 new construction/substantial rehabilitation program, restricted new construction of public housing to 5,000 units, and limited the authority to build new units to those jurisdictions that could prove that demand and inadequate supply of usable, existing units made new construction the only reasonable alternative.

The section 202 program narrowly escaped a similar fate. Congressional efforts and concerns, however, served to maintain the program at funding for 14,000 new units. Under the 1983 act, the section 202 program remained the only housing subsidy authorized to use the section 8 new construction funds.

The 202 program is the most visible elderly housing program, but it has had its problems and attackers. While it has generally produced quality and financially viable housing projects for the elderly and the handicapped, it has also experienced some political controversy. These disputes stem from several problems, including the program's high costs of production; the tendency, at least of the original program, to serve primarily moderate- and middle-income elderly; and the draw that the program makes annually on the Federal budget because of its use of direct loans from the Federal Government at reduced interest rates.

In 1983, the Reagan administration requested that the number of section 202 units built be reduced from 14,000 units (already down from 18,000 units in 1981) to 10,000 units. Efforts to curtail the program are contrary to what the Special Committee on Aging's 1984 survey results demonstrate to be the demand for section 202 units.[3] There are an average of six section 202 units for every 1,000 elderly persons in the country and less than one-fifth of a project's units become vacant annually. As a result, there are over a quarter of a million persons (270,000) waiting to get into the 2,438 section 202 projects nationwide. Waiting lists represent only those who chose to apply—not those who were discouraged by the prospect of a long wait and therefore chose not to apply.

Indeed, the housing needs of several million elderly—housing that is affordable, safe, accessible, and suitable in terms of neighborhood amenities and services—have gone unaddressed. Program cuts have come not only at a time of high demand but also at a time when demand will probably increase. The enormous projected growth of the elderly population suggests the prospect of rapidly increasing shelter and services needs that the Nation has just begun to recognize.

In 1985, $600 million was appropriated for 12,000 units of the section 202 housing. As part of the President's spending freeze to reduce the federal deficit, his fiscal year 1986 budget proposed a 2-year moratorium on new assisted housing production.

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[3] U.S. Congress. Senate Special Committee on Aging. "Section 202 Housing for the Elderly and Handicapped: A National Survey." Committee print, 98th Congress, 2d session. Washington, DC, U.S. Government Printing Office. 1984.

Relative to other Federal housing programs, section 202 received small cutbacks. It has been the target of numerous regulatory and administrative changes, however, which are aimed at making the program more cost effective and targeting assistance to the neediest of elderly and handicapped persons. These recent changes in program direction as well as those continuing policy issues mentioned earlier were the focus of debate during the program's reauthorization in 1985 and will continue to be in the years to come.

Other features of the 1983 housing bill reinforced action taken in 1981 to limit eligibility for rental assistance to the neediest families—those at 50 percent of median income—and to raise the rent contributions of those assisted from 25 to 30 percent of adjusted income. In a compromise forced by those opposed to the rent increase, deductions to adjusted income were raised for families with minor children and for the elderly.

The housing bill of 1983 also reaffirmed the administration's interest in the use and rehabilitation of existing housing, and authorized further experimentation with the administration's housing voucher proposal. Their emphasis on using existing housing is based not only on cost considerations but also on the administration's belief that there is an adequate supply of low- and moderate-income rental housing in most areas of the country. The administration has contended that the need for housing assistance in America can be met most efficiently by providing section 8 certificates or, preferably, vouchers to eligible families for use in existing rental housing.

The shift from new construction to existing section 8 was made for a number of reasons. For the first time, substantial use could be made of the existing housing stock, with a consequent reduction in per unit subsidy costs from those incurred in new construction. It was hoped that use of the existing stock would provide recipients of aid with a greater choice of location and housing type, since they would not be restricted to specific, designated developments. This was seen as a way not only of increasing household satisfaction but also of promoting racial and income integration, as families could move out of concentrated minority-occupied, low-income areas. The higher income the subsidy provided owners could encourage maintenance of the stock, which otherwise faced deterioration; and improvement of already deteriorated units could be fostered by the rehabilitation program.

Fear was expressed by opponents of this reliance on existing housing that in places with low vacancy rates, rents would be driven up for all renters, particularly those of lower income who did not receive a subsidy; that in some places there might be an absolute shortage of standard-quality rental units relative to the number of subsidized households; and that even if there were apparently a sufficient number of units, vacant units might not match the needs of particular types of households, such as large families. As the program has operated, further concern has been expressed that if the acceptable rent is held at a relatively low level, it prevents the dispersion of low-income families out of inner-city areas. Even before section 8 was adopted, HUD had undertaken an Experimental Housing Allowance Program to test the feasibility and advisability of providing a rental subsidy for use in the existing stock. The analysis of this experiment has suggested that rents are generally not increased by the subsidy. Opponents of the shift to exclusive or predominant use of existing housing in subsidy programs, however, maintain that the results are not conclusive, primarily because of the alleged unrepresentative nature of the cities in which the market experiment was conducted.

The Reagan administration has enjoyed considerable success in shifting the mix of additional units assisted by HUD from the more expensive new construction and substantial rehabilitation types to existing units leased in the open market.

The Mortgage Revenue Bond (MRB) program and other rental housing investing tax subsidies have also come under increasing attack from the Reagan administration and Members of Congress concerned about abusive tax shelters and tax-motivated construction not justified by market conditions. The administration's tax reform proposal, introduced in May 1985, would retain most homeownership provisions (but not the deduction for State and local property taxes), although lower tax rates would lessen their value to taxpayers who itemize their deductions. However, virtually all rental housing incentives, including the MRB program, would be ended. The MRB program, in particular, has led to the establishment of State housing finance agencies, some of which have established innovative housing programs for the elderly.

### *(1) Vouchers*

As an alternative to conventional public housing programs, the Reagan administration supports a system under which low-income families receive vouchers, similar to food stamps for housing which they can then use to find housing on the private market. The voucher subsidy is for the difference between 30 percent of the family's income and the fair market rent of a suitable sized unit, although the actual rent may be more or less than the fair market rent. These vouchers were originally to be used principally in conjunction with the New Rental Rehabilitation and Development Program established under the Housing Act of 1983. This association, however, has been ended by the fiscal year 1986 appropriation act.

Advocates of the voucher program argue that, like the section 8 certificate programs, the voucher system would avoid the segregation and warehousing of the poor in housing projects and would allow low-income families to choose where they live—all at less cost than a new construction program. In their view, it would on the one hand provide an incentive to families to search for lower rent, though standard quality, units; on the other hand, it would permit those who valued housing highly, to rent better quality or larger units by paying more of their income for rent. Recipients of section 8 certificates do not have this option. Moreover, since the contract is for 5 years rather than 15, less budget authority need be appropriated in any 1 year for the same number of assisted families.

The voucher system has been met with skepticism by Congress and by many housing advocates. Critics of the program point to a shortage of decent, low-cost housing in the largest cities and question whether vouchers will provide real help to those most in need or whether they will simply encourage private landlords to increase rents because they know tenants have additional funds available. And since the vouchers are only authorized for 5 years, critics raise the point that they do not represent a long-term commitment to providing housing for the poor. They believe the budget savings are illusory, since the need will continue and, presumably, additional funds will be appropriated to continue assistance at the end of the 5-year period. The fiscal year 1985 appropriation act funded 42,000 vouchers, of which 38,500 are incremental and 3,500 are for replacement of lost section 8 and public housing units; fiscal year 1986 appropriations included 39,500 additional vouchers.

### *(2) Low-Income Targeting, Tenant Rent Contribution*

The Omnibus Budget Reconciliation Act of 1981 also reduced the income eligibility limit to 50 percent of the median income in the local area from the previous limit of 80 percent, except for 10 percent of those admitted to units available before the act, and 5 percent of those renting units becoming available after the act. The percentage of those with incomes from 50 to 80 percent of median admitted to earlier available units was increased from 10 to 25 in 1983, but 5 percent was kept for those becoming available after the act. It was assumed that this provision would better match low-income housing programs with those who are most in need of assistance. This change was to apply to new tenants only; the continued eligibility of current tenants with incomes above 50 percent of median income was unchallenged. HUD regulations implementing these changes in the law were promulgated in 1984.

There have been complaints that HUD has implemented these regulations in an inflexible manner. The House housing bill, H.R. 1, contains a provision that would eliminate income restrictions on housing assistance. There was no attempt either in full committee or subcommittee to strike this provision, but it is likely to meet some opposition from some Members of the Senate when they consider the bill or meet in conference.

Report language regarding the targeting issue was included in the Senate committee report (Report 99–129, pp. 14–15) accompanying the housing appropriations bill passed in August. This language directed HUD to use more flexibility when seeking to retroactively restrict admissions to a lower income mix. As the funding for section 202 housing becomes harder and harder to obtain, there will be continued efforts by some to focus the limited resources on the very poorest. This may be difficult to do with opposition in the House and since the program has historically served a more middle- and low-income population.

### *(3) Handicapped Setaside*

Another issue that resurfaced during consideration of H.R. 1 is the allocation of section 202 moneys between elderly and handicapped housing projects. The House housing authorization bill for fiscal year 1986, [H.R. 1], includes an amendment adopted in subcommittee that established a setaside of section 202 funds of either

15 percent or $100 million, whichever is greater, for handicapped projects.

Those supporting the setaside argued that there is a need for separation from the elderly projects due to unique problems faced by handicapped facility sponsors. In addition, handicapped advocacy groups submit that such projects have been underfunded by HUD in the past. Also, average processing time for handicapped applications is 2½ to 3 years versus 23 months for elderly projects, due, in large part, to site location problems experienced by sponsors.

Elderly housing advocacy groups showed some concern that the guarantee floor of $100 million could result in curtailed funding for elderly 202 projects during years of fiscal cutbacks. Mandatory cuts which could be implemented under a proposal like the Gramm-Rudman-Hollings amendment to the debt limit bill could shift the proportion of elderly versus handicapped projects substantially away from the elderly. Although the Senate has not passed a housing authorization bill (prior to the December 20, 1985, adjournment), it appeared that the $100 million floor would not be included in a Senate bill, and that the handicapped advocacy groups would be satisfied with the 15 percent guarantee for 202 project funds.

### *(4) Cost Containment*

Cost containment requirements in the 202 program may work to change the program from providing housing with supportive services for the elderly to one of providing only minimal housing. Recent changes made to the section 202 program in order to increase the cost effectiveness of the program and allow more units to be built with the same amount of money include requirements that (1) section 8 recipients in 202 projects pay 20 percent—instead of 25 percent—of household's adjusted income for rent; (2) at least 25 percent of the units in a project be efficiencies; and (3) sponsors limit the size of the units, congregate space, and number of amenities. The establishment of maximum sizes for apartment units and community spaces removes much of the flexibility in design required to meet the changing needs of an aging population. To serve a more frail, elderly population, sponsors need a facility designed with smaller units and more congregate space. Policies of rigidity rather than flexibility may virtually eliminate the possibility of developing a proper facility for an increasingly frail population.

In June 1984, the U.S. General Accounting Office began the previously mentioned review of the HUD section 202 elderly housing program at the request of Senator John Heinz. The focus of the study was to examine the effectiveness of HUD's efforts to control costs through its cost containment requirement; to identify additional opportunities for cost containment; and to establish the characteristics of the program's beneficiaries.

Although the final report is not available, preliminary findings reveal that although cost containment efforts had been successful in lowering costs, cost containment was having some undesirable effects.

Analysis of construction cost data revealed that cost containment projects averaged 16 percent less than the average costs of units in projects built before cost containment. Section 202 loans ranged from 9 to 25 percent less per unit and GAO estimated that these reductions lowered project rents an average of 10 percent. GAO concluded that without cost containment, 202 projects for fiscal year 1985 would have cost an additional $100 million.

There were problems related to the cost containment efforts. Units were, on average, 11 percent smaller; there were more efficiencies, which are less popular than one bedroom apartments; and fewer amenities for the residents.

One of the most significant issues raised by the study relates to the use of fair market rents [FMR] which HUD establishes for an area on the basis of rents tenants are willing to pay for housing. GAO found that FMR's for a particular area play an important role in the ability of the project sponsors to provide quality housing for the elderly. Project rents cannot exceed 120 percent of the FMR's HUD established for an area. The income from project rents is used to pay for a project's operating and maintenance expenses and to amortize project financing cost (principle and interest). Consequently, by controlling the rental income which can be collected, FMR's serve to limit the mortgage financing or loans and, in turn, the projects' construction costs. This makes it difficult for 202 sponsors in areas with relatively low FMR's to provide housing consistent with higher FMR areas.

FMR's preclude the construction of some projects built in one area from being built in another because their cost would be too high. In some cases, efficiency unit FMR's required project sponsors to reduce construction costs by amounts greater than that saved by building efficiencies instead of one bedroom apartments. Another unfair scenario arises when projects in some States are exempted from real estate tax and can afford to use more of the project's rents for financing construction instead of taxes.

GAO discovered that although HUD requires projects with rents in excess of 100 percent of FMR's to comply fully with HUD's supplemental cost containment guidelines, projects with rents within 100 percent did not comply. In fact, no attempt was made to determine whether a project's features were excessive in some cases. Projects with rents over 110 percent were required to be reviewed by HUD headquarters for compliance.

The study also revealed inconsistent application of cost containment. GAO found that FMR's were difficult to establish for newly constructed units because comparables are not available, and adjustments are subjective, and prone to error and abuse. Past problems at HUD with establishing FMR's were reported by GAO in 1980 and included improper documentation and arithmetic errors.

HUD field offices were found to have waived the 25 percent efficiency requirement in some cases and 18 percent of the cost containment projects reviewed had no efficiency units. Furthermore, projects receiving waivers were not required to meet the HUD space requirements.

GAO found that program costs could be reduced further. They estimated that HUD could save an additional $19 million annually if the number of efficiencies reflected the projected single elderly population expected to live in the projects. Efficiencies are estimated to average $2,800 less to construct than one bedroom units, and

80 percent of the tenants in the sample were single when they moved into their projects. Not all elderly are provided with the same amount of space, but all tenants pay the same rent (30 percent of income) regardless of the type of units they occupy. Even though efficiencies are less expensive to construct, sponsors have little incentive to include more efficiencies than HUD requires (25 percent) in view of the effect that lower FMR's for efficiencies can have on project construction cost and financing.

The survey pointed out further inconsistencies in that project costs differed widely within HUD field offices for both the same and different structural types. For example, in one office, high-rise elevator projects cost on average 31 percent more per unit to construct than low-rise elevator projects. And for high-rise and low-rise elevator projects, per unit cost varied within each category by 18 and 20 percent respectively. HUD instructed field offices not to consider project cost in the selection process. Projects with characteristics known to reduce costs, such as smaller units, more efficiencies, or low-rise construction did not receive any additional points toward the modest design goal than projects without these features.

In conclusion, these initial findings strongly suggest that there are numerous cost containment issues that HUD must resolve in order to provide the most elderly with suitable housing, given the limited funds available for the section 202 program.

### (B) BRICK AND MORTAR VERSUS SUPPORTIVE SERVICES

During a period when the Federal commitment to provide housing is in question, some concerns have been raised about the need for additional supportive programs. The primary Federal focus on the "brick and mortar" aspect of housing fails to address the supportive service needs of those being assisted. Further, this emphasis tends to discourage the development of other shelter alternatives that incorporate such services.

#### *(1) Congregate Housing Services*

Since 1971, PHA's have had the authority to use Federal funds for the provision of dining facilities and equipment in public housing projects. (No subsidy was to be provided to cover the cost of meals and other services.) To date, there has been little development of these congregate facilities. A study on long-term care released by the Department of Health and Human Services in late 1981 cited a variety of reasons for this, including: Local housing agencies have had little experience in managing the necessary services; there has been little Federal encouragement and support; and there is no assurance of funds to pay for the services on an ongoing basis. Most services have been provided by local services agencies funded by the Older Americans Act, Medicaid, and the Title XX Social Services Act.

The Congregate Housing Services Program (CHSP) was set up to be a demonstration program, with $20 million appropriated to be spent over a 5-year period. HUD is to evaluate the program and report to Congress on the success of this program. The program's chief function is to help the elderly remain in the rented dwellings as they age, rather than to be institutionalized. Since 1979, $28 million has been distributed to the 64 CHSP projects servicing over 2,700 elderly persons nationwide. Preliminary evaluation of the CHSP indicates it serves those individuals most in need and is more cost effective than formal institutionalization.

The State philosophy of section 202 housing is to foster independent living. Section 202 projects were intended to be neither intermediary care facilities nor standard apartment rental units. Instead, they were meant to provide shelter plus services which are appropriate to the needs of the elderly and handicapped. Although they were originally designed to serve the well elderly, survey results show that the majority of 202 tenants are aging in place and are now in need of more supportive-type services than when they entered the projects. Survey results reveal that the average age of a tenant living in one of the older 202 projects is 78, while the average age of a tenant living in a project built under the new program is only 71. Results also indicate that, overall, 17 percent of these tenants are considered by project administators to be frail.

Although an average of six on-site services are offered per project, the types of services (such as personal care and housekeeping) that will enable this aging-in-place population to remain independent are offered on a very limited and fragmented basis.

There is no single section 202 services model that applies to all projects in this program. As a result, project sponsors are free to interpret service needs in whatever way they choose. In the future, Congress will need to develop uniform guidelines to ensure that 202 sponsors will provide supportive service to help their aging populations to remain in their dwellings as they age, rather than to be institutionalized.

### *(2) Mandatory Meals*

Current policy enables HUD to give 202 sponsors the discretion to adopt a mandatory meal program that requires residents to purchase at least one meal per day, as a condition of occupancy. HUD views this policy, which limits the number of meals but nonetheless permits the mandatory nature of participation, as a compromise between protecting residents' rights and independence, and ensuring residents' nutrition and sponsors' housing and services ideal.

To put the issue in perspective, a March 1985 GAO study found that only 512 of the 903 sponsors of 202 projects offer meals programs, and only 98 of those are mandatory. Seventy percent of residents participating in the mandatory programs report that they are satisfied with them, and 80 percent of all residents in mandatory programs would not leave the program if permitted. Only 17 percent of residents were dissatisfied with the mandatory meal program, 12 percent indicated neither satisfaction nor dissatisfaction.

Many advocates for the elderly object to this program. They believe that to force a resident to participate in a meal program when he or she could and would prefer to prepare his or her own food appears to be an infringement of individual rights, and contradicts the support for elderly independence to which 202 sponsors are dedicated. Residents' complaints about mandatory meals are mostly about the taste of the food, or the cost (averaging $3.21 per meal). Complaints are based on individual preference, and do not seem to follow a pattern; there is no correlation between complaining that the cost of a meal is too high, and the actual cost of the meals in that project, or the individual's income. Sentiments against mandatory meals is strong enough to have led to court cases, although the complaints are always in the minority. In one project serving 300, for example, only 15 residents filed court cases. (The court has always ruled in HUD's favor, as prospective tenants are informed of the mandatory meal policy before signing the lease.)

The adequate nutrition of elderly residents is a primary concern of 202 sponsors, and many aging advocates support the mandatory meal program concept. Many residents do not take the time, have the interest, or even remember to properly nourish themselves. Furthermore, as they age in place, residents are increasingly unable to prepare meals for themselves; twice as many residents over 80 experience this difficulty, compared to those beteen 62 and 79. Consequently, more residents over 80 (77 percent) liked the mandatory meal program, compared to those between 62 and 79 (64 percent). It is possible that as the younger residents (who now dislike the policy) age, they may find themselves increasingly in need of and grateful for the service.

Isolation is another problem of the elderly which this program addressses. Mandatory meals encourage residents to get out of bed, get dressed, and leave the isolation of their rooms for the social atmosphere of the dining room. Daily meals also help project sponsors to conduct informal "resident checks" and to be aware of ailing or missing residents.

It is evident that there are benefits derived from meal programs, but there is some question about whether it is necessary to maintain the mandatory status of existing programs, in order to offer a meal program. Ninety-two percent of mandatory meal managers believe that they could not continue to provide meals if forced to make the transition to a voluntary basis. At the very least, they believe that prices of meals would increase. The reason is that mandatory meals, which receive no Federal money, are running with a very small profit margin; 94 percent of mandatory programs make a profit of less than 10 percent, and 33 are operating at a loss. The number of voluntary meal participants varies widely from day to day, which would make it difficult to run cost-effective voluntary programs. Eighty-nine percent of mandatory program managers say they could not run their current programs cost-effectively with just a 10 percent decrease in participation.

Currently operating mandatory programs were established in good faith with HUD's permission, and some argue that to force them to make what is predicted to be an unsuccessful transition to voluntary status is unfair. The GAO advised against prohibiting these programs, acknowledging the risk of eliminating meals programs entirely.

The mandatory meals provisions of H.R. 1 were discussed during the Banking, Housing, and Urban Affairs conference on reconciliation prior to the December adjournment, and the issue is very likely to be revisited when either a housing bill conference or reconciliation conference meets in 1986. Those who oppose the provision are most concerned with the effect of the prohibition of tying the meals program to the housing contract, and the definition of financial hardship which would be used to determine whether a resident could opt out of the meals program. This debate will continue during the second session of the 99th Congress.

### 3. LEGISLATION

In 1985, very little legislation was signed into law in the housing area. In addition to the Presidents' budget proposal, major authorization bills were introduced in both the House and the Senate, but no floor action took place. Congress was successful in passing an appropriations measure for HUD, that was signed by the President. Tax reform which will affect the housing industry was passed by the House and awaits Senate committee action.

#### PRESIDENT'S BUDGET PROPOSAL

Under the Reagan fiscal year 1986 Budget proposal, outlays for housing programs would decline by $3.9 billion between fiscal year 1985 and Fiscal Year 1988; over 3 years, the total savings will be $15.1 billion from a baseline of $53.2 billion largely due to proposed reductions in the section 8 and Farmers Home Administration housing assistance programs.

The administration's budget proposed to eliminate all funding for new units of section 202 housing in fiscal year 1986 as part of a 2-year moratorium on additional obligations for assisted housing. The section 202 program would continue to be reauthorized through fiscal year 1987 at current authorization levels, but no additional unit reservations would be offered during either fiscal year 1986 or 1987. Commitments of section 8 assistance to existing elderly and handicapped facilities, as well as funding for those under development, would continue to be honored by HUD.

A 2-year moratorium on new construction would have resulted in a loss of approximately 24,000 units of new housing which otherwise would have been built. The 12,000 units provided by Congressional appropriation for fiscal year 1985 represent slightly more than half of the 20,000 units recommended by the 1981 White House Conference on Aging as the minimum annual number of new units needed to keep pace with the growing demand.

The Federal Government provides three major categories of support to assist in the operation of Public and Indian Housing Authorities: outlays are directed toward construction, modernization, and operating subsidies.

The 1986 budget request proposed a 2-year moratorium on new construction activity and a partial 1-year moratorium on modernization. The modernization program in 1986 would be limited to $175 million in 1-year capital funding available to meet emergency needs. In fiscal year 1987, the budget anticipates requesting $791 million in 1-year capital funding for modernization. In the past, modernization has been financed through amendments to existing annual contributions contracts with public housing authorities. These amendments obligated HUD to pay the interest and principal on local tax exempt bonds to finance the repair work. The budget proposed shifting this financing to 1-year direct capital grants. In the transition, fiscal year 1986 funding would be virtually eliminated. In comparison to the fiscal year 1986 request of $175 million for modernization, over $1.6 billion was expected to be committed to the program during fiscal year 1985.

The Federal Government uses an operating-cost formula to provide operating subsidies to Public and Indian Housing Authorities (PHA's and IHA's) to supplement the required tenant rent contributions. The 1986 budget requested approximately $1.1 billion in outlays for operating subsidies for over 1.3 million PHA and IHA units. This request reflects a 1-year freeze in personnel and related expenses, but allows for inflation adjustments for utilities and other nonpersonnel expenses that are generally beyond the PHA's and IHA's ability to control.

The 1986 budget proposed a 2-year moratorium on the provision of additional housing assistance beginning in fiscal year 1986 and continuing through the end of fiscal year 1987. During the period of the moratorium, no additional funding would be requested to support incremental units. However, funding would be provided to a limited number of additional units to replace support lost through demolition or opt-outs and for loan management and property disposition activities. The budget assumes a total of 14,500 replacement units in all. This total includes 3,500 units of section 8 vouchers to provide support for tenants displaced when a section 8 project owner chooses to end participation in the program (opt-out) and for tenants displaced as the result of public housing demolition. An additional 5,000 units would be used in connection with property disposition activities, 5,000 units for loan management activities and the remaining 1,000 units would support conversions from the section 23 program.

In addition the budget proposed a 10-percent fee reduction affecting public housing authorities participating in the section 8 voucher and certificate program. Finally, the budget included a 1-year freeze on fair market rents (FMR's) in both the section 8 existing certificate program and the voucher payment standards at the 1985 published level.

The Congregate Housing Services Program was initiated as a demonstration program to test whether contracting directly with local public housing agencies and section 202 housing sponsors to supply congregate services is more effective than alternative HHS and other social service programs. Contracts executed under this program run for 3 to 5 years and obligations are expected to continue through fiscal year 1987. The administration requested no additional resources for 1986 since current funds are sufficient to close out and evaluate the current demonstrations. No resources left after the demonstrations are completed will be earmarked for the CHSP.

### (B) HOUSING AUTHORIZATIONS

Authorization bills for 1985 were introduced in both the House (H.R. 1) and the Senate (S. 667). The Banking Committee did not act on the Senate bill, and the House bill was reported by the Banking Committee but not voted on in the House. Instead, the

House included some of its provisions in the Omnibus Budget Reconciliation Act (H.R. 3500) which it passed. These slightly liberalize the adjustments to gross income permitted in determining the income used for calculating rent payments by assisted tenants; make some changes in the performance funding system to promote greater equity and efficiency; permit the changes proposed by the administration in the method used for development and modernization funding; make specific requirements in some of the details of section 8 and voucher operation; remove the requirement that vouchers be used substantially in connection with units in the rental rehabiliation program; and in other ways support or make relatively minor changes in various assistance programs, as well as calling for a number of demonstration programs and reports to Congress on various HUD activities. The Senate version of the Consolidated Omnibus Budget Reconciliation Act (H.R. 3128, as amended) does not include these programmatic changes. The measure is now in conference.

The major aging issue in H.R. 1 was whether to modify the current mandatory meals laws.

In response to residents' complaints (and court cases) about mandatory meals/occupancy, the House housing authorization legislation (H.R. 1), would change current policy, so that no sponsor of 202 housing could require a mandatory meal program. Furthermore, current mandatory meal programs would be required to convert to voluntary programs. Congressmen Levin and Vento amended H.R. 1 with a less dramatic modification of mandatory meal policy. The House adopted H.R. 1 with the Levin-Vento amendment and a provision tying meals programs to leases on June 5, 1985. In addition, report language to H.R. 1 defines the financial hardship exemption in a way that some believe would exempt the majority of residents from being required to participate in the programs.

The Levin-Vento language in H.R. 1 applies to section 202, section 236, and section 8 housing. It permits sponsors to continue to mandate one meal per day, but with several qualifications. Sponsors, under this amendment, are required to accept food stamps as payment for meals. Exemptions must be granted to residents whose specialized medical diets, or diet restrictions due to religious practice, are not met by the program. Furthermore, residents whose work arrangement prohibit participation are exempted from the meal program. A refund policy must be established for residents who, having given prior notice, are absent for extended periods of time, or who are hopitalized. The amendment encourages (but does not require) sponsors to arrange home-delivered meals for shut-in, ill residents. If a resident cannot pay for meals without financial hardship, sponsors are required to exempt or subsidize that resident.

The amendment also calls for evaluation, after 18 months, of the cost-effectiveness and benefit to participants in mandatory meal programs. The availability of funding under Congregate Services Act of 1965, Title III of the Older Americans Act, and other Federal programs, which might enable mandatory programs to successfully make the transition to voluntary status, is also to be studied. For the period pending the study, no new mandatory meal programs are to be established and no current voluntary meal sponsors may switch to mandatory programs.

### (C) HOUSING APPROPRIATIONS

Congress' interest during the 99th Congress has focused on efforts to limit expenditures for housing assistance, both through a reduction in the number of units added to the assisted stock and by lowering the subsidy attached to an individual unit. Reservations in assisted housing have dropped from over 400,000 in fiscal year 1976 to an estimated level of 150,000 for fiscal year 1985; appropriated budget authority has dropped from a high of $31.5 billion in fiscal year 1978 to a net $8 billion in fiscal year 1985. In an effort to reduce per unit costs and to reduce required budget authority, assistance has been limited almost entirely to units in existing stock and the voucher program has continued with 5-year terms.

The Department of Housing and Urban Development—Independent Agencies Appropriations Act for fiscal year 1986, H.R. 3038 [Public Law 99-160], appropriates $838.8 million in contract authority and $9,965.6 million in budget authority for assisted housing (public housing, section 8, and vouchers). Of the budget authority, $1,306.5 million is for development of new public housing (5,000), of which 20 percent is for reconstruction of obsolete projects, and $327.6 million for development of Indian housing (2,000 units); $1,500 million is for comprehensive modernization [CIAP]; $1616.6 million for section 8 in conjunction with section 202 projects; $2,468.2 million for section 8—Existing certificates; $922.5 million for section 8 moderate rehabilitation; and $851.2 million for housing vouchers in the section 8 program. These voucher funds are released from primary use with the rental rehabilitation program, and from the restriction to a demonstration program. An additional $75 million is appropriated for each of the rental rehabilitation program and rental development program [HODAG]. Appropriations for operating subsidies for public housing are set at $1,210.6 million.

For housing for the elderly and handicapped, $631 million is made available for loans to nonprofit sponsors of section 202 housing, with the interest rate continued at 9.25 percent. This amount is intended to provide funding for construction of 12,000 units. Congregate housing is funded at a $2.7 million level. This housing appropriation bill was adopted by both Houses November 4, 1985, and signed by the President November 25, 1985.

### (D) CONGREGATE SERVICES HEARING

On October 2, 1985, the House Select Committee on Aging's Subcommittee on Housing and Consumer Interests held a hearing entitled "Maximizing Supportive Services for the Elderly in Assisted Housing: Experiences from the Congregate Services Program," to assess the impact of the Congregate Housing Services Program currently operating under the aegis of the Department of Housing and Urban Development (HUD).

Prior to the hearing, preliminary HUD data indicated that CHSP services could be provided at a lower cost than similar services found in the wider community, especially institutional care. Congress still awaits the now 2-year delayed release of the HUD evaluation of the CHSP, which it mandated to be submitted to Congress in March 1984 Public Law 98–131. Kenneth Bierne, a HUD official, testified that while the final evaluation was forthcoming, it appeared that the CHSP had no effect on delaying institutionalization or mortality.

However, the testimony of a second panel of witnesses, including a CHSP administrator, indicated the following:

1. The CHSP demonstration project made service providers more responsive to residents and provided care at one-third the cost of nursing homes.
2. Existing projects have long waiting lists and demand for services is likely to increase in future years as the population of the elderly in federally assisted housing increases.
3. Providing an intermediate source of care for the elderly poor could delay their entry into nursing homes and ultimately reduce Medicaid costs.

It is the opinion of Chairman Bonker and the subcommittee that the model of service provision demonstrated by the CHSP has been successfully implemented. It is estimated that over 42 percent of those persons residing in federally assisted housing are over age 62, and while this older resident population may not need supportive services at the time of entering a public housing project or section 202 project, as they "age in place" their need for assistance may increase dramatically. The provision of a supportive services package, like the one provided by CHSP, may help these aging residents retain their independence and reduce the need for premature institutionalization.

### (E) TAX REFORM

The housing industry will most certainly be effected by a tax reform package when and if it becomes law. The House adopted a tax reform package in late 1985, but Senate support remains uncertain at this date. Here again, almost all homeownership provisions would remain, including State and local tax deductions. Most rental housing incentives would be scaled down rather than eliminated. The continued use of the MRB program would require that a larger percentage of a building's rental units be made available and affordable to low-income households. Depreciation allowances would be substantially reduced for most newly acquired rental buildings, but much less so for those with a significant number of units for low-income households. Tighter restrictions on tax-shelter losses and related interest deductions, along with a tougher minimum tax would discourage some rental housing construction and rehabilitation. The expected rent increases would significantly exceed any tax savings to low- and moderate-income renters, many of whom are elderly retirees living on fixed incomes.

## 4. PROGNOSIS

During 1985, Congress and the administration did little to advance the cause of providing a decent home and living environment for every American. In fact, many observers believe that the administration is intent on undermining this Federal commitment.

During the last year there were additional attempts by the administration and some Members of Congress to halt all Federal new housing construction funding despite growth in the need for housing. The prognosis for 1986 is not promising for housing programs. The Gramm-Rudman-Hollings legislation's sequester process will have negative impacts on the number of public, Indian, and section 202 units to be constructed; maintenance, rehabilitation, and modernization of public housing; congregate services; Community Development Block Grants; and many other HUD programs that serve older Americans. Sequesters could take place again in the fall of 1986 on fiscal year 1987 funds; these would more than likely be larger than the 4.3 percent fiscal year 1986 sequesters. Therefore, if Congress fails this year and in future years to act on a budget in a manner that falls within the deficit reduction guidelines, housing programs, among others, will suffer across-the-board reductions in outlays, budget authority, and loan limitations.

The administration's fiscal year 1987 budget proposal will probably be tougher on HUD programs than a uniform reduction would be. In fact, a combination of anticipated proposals for rescissions and deferrals would cut the amount of money spent in fiscal year 1986 as well. Although many pundits question whether the President's budget would have much of a chance to pass in Congress, some of its proposals, particularly those that save a substantial number of dollars, will be carefully considered and will attract many budget cutters in Congress.

In sum, the future of expanding housing programs for older Americans does not look bright. However, Congress has, and is likely to continue to, fund current programs at previous year levels. The press away from the brick and mortar approach and toward vouchers for only the very poor will continue throughout the tenure of this administration. Housing program advocates have their work cut out for them.

Finally, future construction in particular will be directed by Congress when enactment of a tax reform measure takes place, and its possible ramifications will be calculated and experienced for years to come.

## B. INNOVATIVE HOUSING ARRANGEMENTS

The single-family house, increasingly void of children, has come to represent the discrepancy between the needs of a burgeoning population of elderly homeowners and the lack of housing alternatives. Recently, several types of solutions to the problems of those elderly trapped in houses too large for their needs and too costly to maintain have surfaced. These include: Home equity conversion plans; shared housing and ECHO, or granny flat arrangements.

### 1. Background Issues

#### (A) CONVERTING EQUITY

Attention has been paid in recent years to financial arrangements which would permit aged homeowners to convert part of their equity into cash, without having to leave their dwellings. These home equity conversion plans [HECP's] offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. They could also provide funds to allow older persons to pay for needed support services, home maintenance, and other needs. Before HECP's, the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

Homes of older Americans are their most commonly held and most valuable asset. Recent statistics indicate that of the three out of every four elderly persons who own their own homes, 80 percent do not have a mortgage. The total value of the equity held by older Americans is over $600 billion. Equally as significant, a large proportion of older homeowners are likely to have relatively low incomes. For example, 6 out of every 10 elderly single homeowners have incomes of $5,000 or less.

There are two distinct types of conversion plans—debt and equity—on which a variety of models are based. Debt plans allow an older homeowner to borrow against home equity with no repayment of principle or interest due until the end of a specified term of years, or until the borrower sells the home or dies. These plans can provide single lump-sum payout to the borrower, a stream of monthly payouts for a given term or—with the addition of a deferred life annuity—guaranteed monthly payouts for life. They are often referred to as reverse mortgages or reverse annuity mortgages [RAM's].

Property tax deferral programs, popular in many States, are a form of debt plan in which older homeowners postpone paying their taxes until they sell their homes or die. In State-initiated deferral programs, the State pays taxes to the local government for the homeowner. These payments accrue with interest as a loan from the State to the homeowner, secured by equity in the home. Upon death or prior sale of the home, the total loan is repaid to the State from the proceeds of the sale or the estate.

Equity plans involve sale of the home to an investor, who immediately leases it back to the seller. Land contract payments of the seller exceed term payments to the buyer, so the older person receives extra cash each month. In addition, the buyer pays for the taxes, insurance, and maintenance. A deferred annuity or other investment purchased with the down payment can provide income beyond the land contract term. These plans are also referred to as sale/leasebacks.

The basic theoretical forms of HECP's have been developed for several years. In general, however, workable instruments have yet to become widely available to the public. One reason for the lack of substantial interest is that the combination of financial benefits and risks associated with the plans has not been sufficiently attractive to borrowers.

### (B) SUPPORTIVE ARRANGEMENTS

Although the Federal Government is supporting several congregate care housing demonstration projects and a few States are establishing congregate housing programs, there is little direct public assistance to fill the gap between totally independent living arrangements and health-care-oriented retirement communities. Accordingly, the private sector has stepped in to provide various options ranging from low-cost elderly housing and board and care facilities to relatively expensive life care communities and retirement communities. Retirement communities differ in the range of housing, social, and health care services they provide. Most provide independent housing, congregate meals, and social and recreational activities. Some also have 24-hour nurse service and wellness clinics, and others provide a continuum of care that includes independent living units, personal care, and nursing home care services.

In the past, the Senate Special Committee on Aging has made a point of scrutinizing the Nation's estimated 300,000 board and care homes serving low-income older persons. The Aging Committee, in 1983, also conducted an investigative hearing on the benefits and shortcomings of the life care industry. One of the Committee's major objectives in 1986 will be to learn more about the demand for and the conditions in the generally subsidized, and loosely regulated area of semi-independent living for the elderly.

### *(1) Board and Care Homes*

Most of the more than 1 million residents of boarding homes, and foster, adult, or domiciliary care facilities receive some form of public assistance. Managers of the 300,000 such homes have often been criticized for inadequate safety and security measures, poor care, abuse of the residents, and even financial fraud.

In 1976, after a number of fires in board and care homes, Congress added to the Social Security Act a new section 1616(e), known as the Keyes amendment. This provision requires that for group living arrangements in which a significant number of SSI recipients reside, States establish and enforce standards that govern such matters as admission policies, safety, sanitation, and protection of civil rights. Congress in making this change sought to prevent the Supplemental Security Income [SSI] program from becoming a source of funds for substandard institutions.

The Keyes amendment does not mandate Federal regulation or licensure of board and care homes, and the only enforcement sanction available to punish violators of the provisions is the power to reduce the SSI checks of residents of homes not in compliance with State regulations, including States with no regulations at all. Although all States now have health and safety provisions in law, Federal efforts to enforce board and care home standards have been hampered by lack of direct Federal funding of these facilities: SSI benefits are paid directly to board and care home residents, not to the facility. This contrasts with nursing homes, where Federal Medicaid and Medicare Programs pay the provider of care directly. Consequently, the Federal Government has been able to achieve stronger regulatory requirements for skilled nursing and intermediate care facilities.

### *(2) Life Care Communities*

Life care communities, also called continuing care communities, typically provide housing, personal care, and nursing home care, and a range of social and recreational services as well as congregate meals. Residents enter into a contractual agreement with the community to pay an entrance fee and monthly fees in exchange for benefits and services. The contract usually remains in effect for the remainder of the resident's life. In its study on life care, the Pension Research Council of the University of Pennsylvania developed a definition of life care communities which includes providing specified health care and nursing home care services at less than the full cost of such care as the need arises. Life care communities meeting this definition numbered about 300, with 100,000 residents in December 1981. Life care defined in this way is viewed as a form of long-term care insurance, because communities protect residents against the future cost of specified health and nursing home care. Like insurance, residents who require fewer health and nursing home care services in part pay for those who require more such services. Also, like insurance pricing policies, entrance fees usually are based on actuarial and economic assumptions such as life expectancy rates and resident turnover rates.

Entrance fees range among life care communities from approximately $20,000 to over $100,000, and are based on such factors as the social and health care services provided, the size and quality of independent living units, and the amount of health care coverage provided. Life care communities do not cover acute health care needs such as doctor visits and hospitalization. Studies have shown that the average age of persons entering into life care communities is 75. In independent living units, personal care units, and nursing home units, the average ages are 80, 84, and 85, respectively.

About 97 percent of all life care communities have nonprofit income tax status. Many are affiliated with a religious organization, although the religious organization may not have legal responsibility for the communities' operations and financial solvency. In recent years, the for-profit sector has shown an increased interest in developing and operating life care communities.

There also are about 300 communities which require of residents entrance and monthly fees in exchange for specified benefits, but which are not considered a form of long-term care insurance. While these communities have a range of housing, social, and health care services including nursing home care, they do not cover the cost of most nursing home care services. Such care is paid for by the residents on a fee-for-service basis, that is, as expenses are incurred.

Problems have been discovered in some communities. Some life care communities have functioned using lifespan and health projections that are not actuarially sound and future revenues and cost projections that are incorrect. Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned even on a prorated basis. Recently, there has been growth in the number of private, nonprofit corporations which sponsor life care facilities. While the individual facility is clearly nonprofit, the corporation that organizes and develops the project is often a for-profit organization. The profitmaking goals of the developer may conflict with the financial stability of the nonprofit corporation; for example, in order to attract consumers and quickly raise funds, the pricing structure may be established too low to provide both profit and future financial stability.

While most life care communities are managed effectively, some have faced financial and other problems. Being a relatively new and growing phenomenon, life care is just beginning to be understood and regulated. California, in 1969, was the first State to regulate life care. Today, only 13 States regulate the operation of life care communities. These States are: Arizona, California, Colorado, Florida, Illinois, Indiana, Maryland, Michigan, Minnesota, Missouri, Oregon, Pennsylvania, and Virginia. New York, which bans prepaid nursing home care, effectively prohibits life care arrangements. There is little uniformity in the way these facilities are regulated by the States. Some States require operators to make public ownership and financial disclosures, others do not. Similarly, some States regulate resident rights and others do not. Few if any of the States offer adequate protection from the operator who deliberately seeks to use complex profit/nonprofit business structures and non-arms-length transactions to enhance his personal wealth at the expense of the life care residents. The House version of the 1986 Federal Trade Commission Authorization Act contains a provision which would require the FTC to study the life care industry, issue a trade rule if warranted, and report to Congress within 2 years. As of this printing, this legislation is pending conference. Senators Heinz and Glenn support this study.

The University of Pennsylvania's Wharton School study suggested that States, when regulating life care, should address issues such as: Facility certification and accreditation; management of escrow accounts, maintenance of reserve funds, required financial disclosures; strengthening preconstruction disclosure requirements for bond holder; and the development of methodologies to be used to test the ongoing financial viability of the community.

### *(3) Shared Housing*

Shared housing can be best defined as facilities housing at least two unrelated persons where at least one is over 60 years of age, and in which common living spaces are shared. It is a concept which targets single and multifamily homes and adapts them for elderly housing. Shared housing can be agency-sponsored where usually 4 to 10 persons are housed in a dwelling, or it may be a private home/shared housing situation in which there are usually three or four residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is that of companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with the means to maintain these homes. In some instances, elderly who otherwise would be overhoused can help families who may be having difficulties in finding adequate housing arrangements.

From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned large houses and buildings could be made suitable for shared housing with very little renovation. Dennis Day Lower, a director of the Shared Housing Resource Center in Philadelphia, has pointed out that shared housing is extremely cost effective when compared to new construction. He has noted that per unit capital costs could be as much as 50 to 60 percent lower using shared housing.

There are various impediments to shared housing. Among the most prominent are zoning laws and reduced supplemental security income and food stamp payments of participants. Congress recognized the need to overcome these impediments, and has begun to act by including a provision in the Housing Act of 1983 for section 8 rental assistance to be used with shared housing. Under this provision, the existing and moderate rehabilitation programs of section 8 can be used to aid elderly families in shared housing. HUD will issue minimum habitability standards to insure decent, safe, and sanitary housing as an eligibility activity under the Community Development Block Grant Program.

Several shared housing projects are in existence today. Anyone seeking information on establishing such a project or looking for housing in a project can contact two knowledgeable support services. One is Operation Match, which is a growing service now available in numerous communities throughout the country. It is a free public service open to anyone 18 years of age with no sex, racial, or income requirements. Operation Match is a division in the housing offices of many cities, and helps match people who are looking for an affordable place to live with those who have space in their homes and are looking for someone to aid them with their housing expenses. Some of the people helped by Operation Match are single, working parents with children, those in need of short-term housing, elderly people hurt by inflation or health problems, and the handicapped who require live-in help to remain in their homes.

The other source of information in shared housing is the Shared Housing Resource Center in Philadelphia. It was founded in 1981, and acts as a linkage between individuals, groups, churches, and service agencies that are planning shared households.

### *(4) Accessory Apartments and Granny Flats*

Accessory apartments have been accepted in communities across the Nation. These apartments were occupied by members of the homeowner's family, and, therefore, accepted into the neighborhood. Now, with affordable rental housing becoming more difficult to find, various interest groups, including the low-income elderly, are taking a closer look at this type of housing.

Basically, accessory apartments are another form of shared housing, except that each unit has its own kitchen. Thus, this form of housing undergoes the same zoning restrictions and impediments already discussed in the section of this report concerning shared housing. A few jurisdictions have modified local zoning rules to permit accessory housing, primarily in California.

Another innovative housing arrangement under discussion is the "granny flat" or "ECHO" flat, first constructed in Australia and recently introduced in this country. "Granny flats" were constructed as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence for both parties. In the United States, we refer to such living arrangements as "ECHO units," an acronym for elder cottage housing opportunity units. ECHO units are small, freestanding, barrier free, energy efficient, and removable housing units that are installed adjacent to existing single-family houses. Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit corporations or local housing authorities.

Rigid zoning laws, lack of public information, and concern about adverse changes to the neighborhood, and therefore, property values, are the major barriers to the development of ECHO housing. Many civic leaders, public officials, and organizations are reporting increased interest in the possibility of ECHO units for their jurisdictions. At this time, there is no Federal legislation dealing with this concept.

## 2. LEGISLATION

### (A) HOME EQUITY CONVERSION

A reverse mortgage insurance plan was proposed by the Department of Housing and Urban Development in 1983. The insurance plan had three basic purposes: First, to meet the special needs of elderly homeowners by insuring the conversion of home equity into liquid assets; second, to encourage and increase the involvement of lenders and secondary market participants; and third, to permit evaluation of data regarding demand, supply, and appropriate Federal participation. The proposed demonstration's authority provided for insurance coverage for up to 1,000 reverse mortgages through September 1986.

House-Senate negotiations on the HUD proposal led instead to language requiring HUD to evaluate existing reverse mortgage programs. The evaluation was to be submitted to Congress at the end of 1984. As of November 1985, a draft report was receiving HUD clearance.

A bill to clarify Federal tax treatment of residential sale/leaseback transactions [S. 1914] was deleted during House-Senate negotiations on the 1984 tax legislation bill. The bill, introduced by Senator Specter, would have created a safe harbor for sale/leaseback transactions so that the tax treatment would be the same as that of conventional home sales and rentals. Such legislation is needed due to current uncertainty about the tax treatment of sale/leasebacks, which has discouraged older homeowners from utilizing this form of home equity conversion.

The final version of the legislation was substantially different from the original version of S. 1914 due to add-ons to the bill during review by the Senate Finance Committee. These additions resulted from concern by both the Finance Committee staff and the Treasury Department that increased use of sale/leasebacks involving the elderly might lead to annual tax revenue losses of up to $100 million. These estimates were challenged by the bill's supporters.

Senator Specter reintroduced his home equity conversion bill in the 99th Congress [S. 324], and Representative Lawrence Smith of Florida introduced a companion bill in the House [H.R. 3204]. In addition, a bill to authorize HUD to insure home equity conversion mortgages [H.R. 2292] was introduced in April 1985. The bill, introduced by Representative Worthy, would have authorized HUD to insure up to 1,000 mortgages by September 30, 1985.

Finally, in August 1984, the Social Security Administration issued its first formal communication on how the proceeds of home equity conversion plans will be treated in determining eligibility and benefit levels for supplemental security income. This document (SSA Pub. No. 17-004, SSA Program Circular 09-84-OSSI) describes various types of home equity conversion plans and indicates the specific program operations manual system instructional references that govern how the proceeds of the different plans are to be treated.

### (B) LIFE CARE—IMPUTED INTEREST

The Senate Special Committee on Aging, on May 25, 1983, conducted a hearing entitled, "Life Care Communities: Promises and Problems," which marked the first time a congressional committee had addressed this fast growing and significant housing, service, and health care option for the elderly. The Aging Committee received testimony from residents of two life care communities, from a team of nationally recognized experts who advocated the increased development of life care, and from representatives of State and Federal law enforcement and regulatory agencies that have had experience with some of the unique problems associated with this industry.

The committee has since followed closely the related legislative initiatives and played a role in the development of provisions in a recent tax bill to protect residents of life care facilities from imputed interest taxation.

Residents who pay entrance fees may be affected by the Deficit Reduction Act of 1984, which added section 7872 of the Internal Revenue Code, and which was amended in 1985. This law may treat certain interest free loans as interest bearing loans for tax purposes. Regulations have not been issued on this law, however, Congress intended for this law to reduce the tax avoidance aspects of interest free loans made by individuals in a higher tax bracket to individuals in a lower tax bracket. The law could possibly apply to transactions between residents and life care communities. Under the law, the resident could be considered to have transferred the use of the principle (entrance fee) to the community. The lender (in this case the resident) would be required to recognize a federally established rate of interest, and pay a tax on this income. The borrower (in this case the community) would be deemed to have a deduction equal to the amount of interest the lender would be deemed to have received.

Because the 1984 legislation could have had the effect of increasing the cost to reside in a life care community, Chairman John Heinz and other members of the Aging Committee were concerned that hardships would occur for existing residents. Prospective residents could be discouraged from moving into life care communities, which could jeopardize the communities' financial solvency. If a community goes bankrupt, existing residents will lose their entrance fees, which is their investment in lifetime housing and health care benefits. For most residents, the entrance fee represents a major part of their assets.

In 1985, an amendment (offered by Senator John Heinz) as part of the simplification of imputed interest legislation (H.R. 2475) was passed by the Senate to exempt from the imputed interest provisions refundable entrance fees of $90,000 or less (to be indexed in subsequent years for inflation) paid by residents age 65 and older who move into independent units in life care communities. The subsequent conference report on the amendments (House Report No. 99-250) specifies that entrance fees that are wholly or partially refundable after a brief period of time (e.g., for 6 months), and fees that are refundable on a declining pro rata basis over a somewhat longer period (up to 8 years) are to be treated as advance payment of fees and not as loans under present law and thus not subject to taxation under the imputed interest rules.

While certain Federal agencies such as the FTC, SEC, HHHS, HUD, and FBI have from time to time been involved in limited aspects of life care, there is no significant, direct Federal involvement in this industry at this time. It is clear that if any comprehensive Federal response is to be developed, it will need to come from some congressional initiative. Bills that address the life care phenomenon have been introduced since the 95th Congress. As passed by the House, the Federal Trade Authorization Act of 1985 (S. 1078) would direct the FTC to study unfair and deceptive practices in the life care industry and to report its findings to Congress within 2 years of enactment. The Senate version of the bill does not contain this provision. As of December 1985, conferees had not met on the bill. However, Senators Heinz and Glenn have urged the Senate conferees to accept this House provision.

Life care can become increasingly significant for growing numbers of people and for the society as a whole. But just as clearly, potential residents need to understand the nature of the financial risks involved and each facility must be soundly based and operated under adequate financial planning. Otherwise, the promise of life care can become illusory and the loss to residents catastrophic.

### 3. PROGNOSIS

Innovative housing programs will become more and more essential in providing basic housing and support services for our Nation's elderly, handicapped, and poor. But Congress, with its full platter of issues, is unlikely to focus much attention on innovative housing for the elderly in 1986. Hearings will be in order, but action on home equity conversion clarification and further life care facility policy is not a high priority. It is very unlikely that such legislation will reach the President's desk for signature this year.

There should be strong growth, however, in interest in, if not attempts to use, home equity conversion transactions. This concept has become very attractive to many of the large number of older Americans who have built substantial equity in their homes yet are faced with meeting the high cost living on fixed incomes.

The life care industry is expected to grow by leaps and bounds over the next several years, mainly appealing to the upper middle and upper income groups. There is consideration being given to life care facilities for lower income Americans, primarily those that have been able to purchase a home during their lifetime. These efforts will be slow in evolving, however, and will be undertaken primarily by nonprofit life care interests. The for-profit life care interests will continue to expand during 1986.

Shared housing will become a more necessary option for older Americans in future years as the cost of maintaining a single residence becomes a larger burden than many elderly can afford. The need for quality board and care facilities, accessory apartments, and granny flats will grow with the increase in the number of older Americans, but the role of the Federal Government will not be significant in 1986.

# Chapter 10

# ENERGY ASSISTANCE AND WEATHERIZATION

## OVERVIEW

During the 12 years since OPEC nations instituted the full scale embargo on oil sales to the United States, energy use and conservation have become major domestic policy issues, particularly for those who monitor the economic security of the elderly and poor.

A number of Federal programs have been instituted to ease the energy cost burden for needy individuals. The most significant of these are the Low-Income Home Energy Assistance Program [LIHEAP] and the Department of Energy's Weatherization Assistance program. Over the years these programs have undergone modifications in response both to growing need and apparent deficiencies in design and implementation, and have come under increasing scrutiny in the effort to reduce Federal budget deficits.

Although these two programs have played an important role in helping millions of America's poor pay for their basic energy needs and weatherize their homes, there is a widening gap between existing Federal resources and the needs of the population these programs were intended to serve. The Reagan administration has been unsuccessful in its efforts in recent years to substantially cut LIHEAP and eliminate the DOE weatherization program. Congress has, for fiscal year 1986, continued to view these programs as the Federal Government's only significant efforts to assist the elderly and poor with their escalating energy costs and has maintained funding for them.

## A. BACKGROUND

The radical changes in world oil markets following the 1973 embargo brought equally radical changes in household budgets of Americans. The proportion of income required to purchase essential energy supplies rose dramatically, and changes in the cost of this basic commodity brought changes in the cost of many other necessary items. Although these changes had different impacts depending on a household's income and fuel requirement, during the past 12 years the pressure for change in consumption patterns and the erosion of real spending power due to energy inflation has been unrelenting. The rising cost of energy has had a particular effect on the elderly and those with low incomes, who consume relatively less energy than other households, but pay a larger portion of their disposable income for fuel.

The rise in energy cost in relation to income has been the impetus behind congressional enactment of both the Low-Income Energy Assistance Program and the Weatherization Assistance

Program. Between 1972 and 1979, electricity costs rose 84 percent, natural gas prices increased 150 percent, and fuel oil costs rose 258 percent. These figures were well above the overall increase of 74 percent in the Consumer Price Index for the same period.

According to the Department of Energy's residential energy consumption survey, beginning in 1979 and continuing for the next 2 years, the average household paid $100 more each year for household energy. In 1982, however, the increase slowed significantly. As pointed out by the Department of Energy (DOE), this slowdown in the rate of increase occurred because the increase in prices was nearly offset by the decrease in consumption. Overall, prices rose 14 percent from 1981 to 1982, while consumption dropped 10 percent.[1]

The U.S. Bureau of Labor Statistics reports that the consumer price index for household fuels rose 0.7 percent from December 1984 to December 1985. This figure reflects a 5.5 percent increase in the cost of fuel oil, a 2.9 percent increase in the cost of electricity, and a 4.6 percent decrease in the cost of natural gas. The 1984 average price of heating fuels increased about 1 percent and was a reversal of a trend of several years, during which energy prices increased at a rate much faster than the general inflation rate. Between December 1980 and December 1985, household fuel costs have risen 32.6 percent.

The DOE has estimated that energy consumption is higher for households with larger incomes. There is a large difference in average energy consumption and expenditures among households with different income. During the 4-year period 1978–81, the highest income households used about 70 percent more energy than the lowest income groups. It was noted that their living quarters are about twice the size of the lowest income group, living quarters, and they usually use more appliances. From 1978 to 1980, there was a trend toward parity, with high-income households lowering their energy consumption more than low-income households did. The data for 1981, however, show a slight reversal of this trend. Households earning less than $5,000 reduced their consumption by an estimated 11 million Btu's, while households with income over $24,000 did not show a continued drop.[2]

Rising energy prices affect all income groups, so that energy expenditures increased across-the-board from 1978 to 1981. Average expenditures for households in the highest income group ($1,333) were almost 75 percent more than those of the lowest income group ($766). In contrast, however, expenditures increased much more for the lower income group than the higher.[3]

During this 4-year period, beginning in 1978, expenditures for the lowest income group increased 47 percent, in nominal dollars, while expenditures for the higher group increased 24 percent. Additionally, expenditures as a percentage of income are much higher for lower income group. Low-income households typically spent about 20 percent of their income on energy, while high income households spent from 3 to 4 percent of their income on energy.

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[1] Energy Information Administration, 1978–82 Residential Energy Consumption Surveys.

[2] Ibid.

[3] Ibid.

Among poor households, the burden of energy expenditures is highest in the Northeast and North-Central portions of the country. For example, in the Northeast, poor households (below 100 percent of the poverty level), paid 29 percent of their income for household energy.[4]

The HHS February 1985 report to the Senate Appropriations Committee includes projections regarding the expenditures for residential energy by low-income households. These figures reflect little change in the cost of energy for the poor between 1984 and 1985 (see table 1). The 1985 average heating cost estimate for low-income households is down slightly due to weather and fuel prices (see table 2). However, DHHS states that average heating costs for households receiving LIHEAP tend to be higher, and their income lower, than other low-income households.

TABLE 1.—ESTIMATED EXPENDITURES FOR ALL RESIDENTIAL ENERGY BY LOW-INCOME HOUSEHOLDS

| | Fiscal year— | | Percent change |
|---|---|---|---|
| | 1984 | 1985 | |
| National | $942 | $951 | +1 |
| Northeast | 1,176 | 1,204 | +2 |
| North Central | 1,057 | 1,049 | −1 |
| South | 871 | 858 | −2 |
| West | 769 | 809 | +5 |

Source: Report on the Low-Income Energy Assistance Program as Requested by the Senate Committee on Appropriations U.S. Department of Health and Human Services, Social Security Administration, Office of Family Assistance, Office of Energy Assistance, February 25, 1985.

TABLE 2.—ESTIMATED EXPENDITURES FOR HEAT BY LOW-INCOME HOUSEHOLDS

| | Fiscal year— | | Percent change |
|---|---|---|---|
| | 1984 | 1985 | |
| National | $426 | $420 | −1 |
| Northeast | 625 | 635 | +2 |
| North Central | 513 | 496 | −3 |
| South | 340 | 316 | −6 |
| West | 319 | 337 | +6 |

The situation is even worse for the low-income elderly because they are particularly susceptible to hypothermia—the potentially lethal lowering of body temperature. The Center for Environmental Physiology in Washington, DC, has reported that experts on this subject estimate that hypothermia may be the root cause of death for up to 25,000 elderly people each year. The center reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold. In addition, the situation can worsen many preexisting conditions and diseases in older adults, such as arthritis. Although another disease is ultimately listed as the cause of death, the center maintains that many deaths may be causally related to hypothermia.

In recent years, congressional efforts to ease the burden of high energy costs on the elderly and poor have taken two principle forms. First, since 1977, Congress has appropriated money to provide aid for fuel related emergencies to households at or below 125 percent of the poverty line. The Low-Income Home Energy Assistance Program grew from $200 million in crisis assistance in 1977, to $2.1 billion in fiscal years 1985 and 1986. Funds are distributed to States on a formula basis which takes into consideration climate and energy needs of the population.

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[4] Ibid.

Second, in 1975, Congress enacted the Emergency Energy Services Conservation Program, designed to provide energy relief to needy households by increasing the energy efficiency of homes through insulation and repairs. This has developed into a $190 million weatherization assistance program operated and administered by the Department of Energy.

### 1. THE LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

The precursors of the current Low-Income Home Energy Assistance Program (LIHEAP) were a series of 1-year programs in fiscal years 1977–79 that were administered by the Community Service Administration [CSA]. Although the names and operation procedures of these programs differed year to year, they all were limited to a $200 million annual appropriation and oriented to crisis intervention. Generally, potential low-income recipients had to demonstrate that they faced an imminent energy-related emergency, such as a shutoff of their home heating fuel supply or a breakdown of their primary heating source. In such cases, aid could be provided to pay utility bills or provide in-kind benefits, such as space heaters or blankets.

Between the winter of 1979 and 1980, the price of home heating oil doubled. In response, Congress expanded aid sharply by creating a three part energy assistance program at an appropriation level of $1.6 billion: $400 million to the CSA for continuation of its crisis intervention programs; $400 million to the Department of Health and Human Services [DHHS] for one-time payments to recipients of supplemental security income [SSI]; and $800 million to DHHS for distribution as grants to States to provide supplemental energy allowances.

In 1980, Congress passed the Home Energy Assistance Act as part of the crude oil windfall profit tax legislation. Enactment of this law was based on the perception that those who would potentially suffer the most under decontrol, would be aided. The act authorized $3.12 billion for LIHEAP in fiscal year 1981. During the appropriation process, however, the funding level and the distribution formula were changed. In its final form, $1.85 billion was appropriated, and the distribution to States was based on a complex formula that was heavily weighted toward States with cold climates and large fuel oil consumption.

Three basic types of energy-related aid are permissible under the LIHEAP. First, States may make payments to assist households in paying their fuel bills for either heating or cooling. There are virtually no restrictions on the manner in which this assistance is provided (cash payment, vouchers, vendor lines of credit, and tax credits are the most common). Second, States must use a reasonable amount of their allotment to provide energy-related emergency assistance, as was provided under the old CSA crisis intervention program. Finally, States may use up to 15 percent of their LIHEAP funds to the next fiscal year without affecting the calculation of future allotments. In an effort to provide greater flexibility, the law allows up to 10 percent of a State's allotment to be transferred from LIHEAP to other Federal block grant programs and, conversely, funds may be transferred into LIHEAP from other grants.

At the discretion of the State, LIHEAP payments can be made to households where one or more persons are receiving: Supplemental Security Income, Aid to Families with Dependent Children, Veterans' Pensions, or Dependency and Indemnity Compensation. States can also elect to make payments to households with incomes that are less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Table 3 indicates the income ceiling of one-person households by State on the basis of the 60 percent median household determination for fiscal year 1986. The income levels range from $6,715 in Arkansas to $11,930 in Alaska. In 1985 the alternate income ceiling, 150 percent of the poverty guideline, was $7,875 in all States except Alaska ($9,840) and Hawaii ($9,060). The ceiling in 1986 for a one-person household is $8,040 for all States except Alaska ($10,050) and Hawaii ($9,255).[5]

*Table 3—60 percent of median income for one-person household in fiscal year 1986*

| State | |
|---|---|
| Alabama | $7,836 |
| Alaska | 11,930 |
| Arizona | 8,596 |
| Arkansas | 6,715 |
| California | 9,973 |
| Colorado | 10,075 |
| Connecticut | 11,763 |
| Delaware | 9,883 |
| District of Columbia | 8,954 |
| Florida | 7,941 |
| Georgia | 8,568 |
| Hawaii | 9,863 |
| Idaho | 7,490 |
| Illinois | 9,589 |
| Indiana | 8,400 |
| Iowa | 8,049 |
| Kansas | 8,601 |
| Kentucky | 7,518 |
| Louisiana | 8,721 |
| Maine | 7,543 |
| Maryland | 11,068 |
| Massachusetts | 10,604 |
| Michigan | 9,195 |
| Minnesota | 9,605 |
| Mississippi | 6,850 |
| Missouri | 8,670 |
| Montana | 7,887 |
| Nebraska | 8,143 |
| Nevada | 10,765 |
| New Hampshire | 9,489 |
| New Jersey | 11,372 |
| New Mexico | 7,459 |
| New York | 9,528 |

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[5] Federal Register. Vol. 51, No. 28. February 11, 1986. pp. 5105–5106.

| *State* | |
|---|---|
| North Carolina | 7,913 |
| North Dakota | 8,214 |
| Ohio | 8,831 |
| Oklahoma | 8,476 |
| Oregon | 8,238 |
| Pennsylvania | 8,821 |
| Rhode Island | 9,100 |
| South Carolina | 8,036 |
| South Dakota | 7,487 |
| Tennessee | 7,513 |
| Texas | 9,138 |
| Utah | 8,012 |
| Vermont | 7,938 |
| Virginia | 9,813 |
| Washington | 9,418 |
| West Virginia | 6,911 |
| Wisconsin | 9,041 |
| Wyoming | 8,886 |

For fiscal year 1985, States estimated that they spent about $1.48 billion for heating assistance for approximately 6.8 million households with an average benefit of $200. Approximately $195 million was spent on energy crisis assistance for over 895,000 households and about $214 million was used for weatherizing some 220,000 households. Also served were about 24,000 households who received summer crisis assistance at a cost of over $28 million.[6] There remains a gap, however, between those in need (those eligible) and those currently receiving LIHEAP benefits. Excluding individuals who may be categorically eligible for benefits (households where at least one individual is receiving food stamps, Aid to Families with Dependent Children, certain Veteran's benefits, or Supplemental Security Income), the Congressional Research Service estimates that 23.4 million households meet the income eligibility requirements for LIHEAP benefits. This estimate is based on the March 1984 Current Population Survey [CPS].

### 2. THE DEPARTMENT OF ENERGY WEATHERIZATION ASSISTANCE PROGRAM

The Department of Energy's [DOE] Weatherization Assistance Program has been authorized under the Energy Conservation and Production Act of 1976, as amended. Its authority expired at the end of fiscal year 1985, and for fiscal year 1986 it is operating under a continuing resolution at $190 million. The program is designed to reduce heating and cooling costs in low-income households.

Through this program, funds are made available to States, which in turn allocate dollars to nonprofit agencies for purchasing and installing relatively low cost materials such as insulation, storm windows, doors, and other such materials. Federal law allows a maximum average expenditure of $1,600 per household in a State. To be eligible for assistance, household income must be at or below 125 percent of the Federal poverty level ($9,050 for a family of two as specified in the 1986 Federal Poverty Income Guidelines). States, however, may raise their income eligibility criterion to 150 percent of the poverty level to conform to the LIHEAP income ceiling. Also eligible for assistance are households with persons receiving AFDC, SSI, or other cash assistance payments. Like LIHEAP, priority for assistance is given to households with an elderly individual (age 60 and older) or a handicapped person. The program has served 1,489,562 million homes from the program's inception through September 1985. Approximately 728,604 of these homes had a person age 60 or older. In 1985, 207,291 homes were weatherized.

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[6] U.S. Department of Health and Human Services. Social Security Administration. Office of Family Assistance Low-Income Home Energy Assistance. Memorandum Transmital No. SSA-IM-85-24. August 27, 1985.

Among the program's intended benefits are:

—improved energy efficiency in the homes of program recipients,

—reduced fuel bills for program recipients,

—reduced national energy consumption, and

—increased employment opportunities in areas related to installing and manufacturing low-cost weatherization materials.

A DOE-sponsored evaluation of the Weatherization Assistance Program published in 1984 (based on 1981 data) showed that: [7]

—The program reaches elderly persons in accord with its statutory priority requirement.

—The program saves, on the average, about 13 percent of a home's heating energy. The study found that 50 percent of the weatherized homes surveyed had an energy savings of 10 percent or more; 23 percent had a savings of 20 percent or more; and 23 percent used more energy the year after weatherization.

—Energy savings relate to the type and cost of weatherization assistance materials. Homes receiving the most extensive weatherization services, insulation plus storm windows or doors, saved more than twice as much energy as weatherized homes that were not insulated. Insulation was a key measure for producing energy savings in the homes weatherized.

—Energy savings derived from a particular energy improvement, however, can be precisely determined only by measuring energy consumption under identical circumstances before and after the improvement is made. This condition is impossible to meet because conditions are always changing. For example, thermostate settings and energy use in a home changes from year to year.

—More of the homes weatherized are in colder weather zones and fewer are in temperate and warm weather zones.

As a result of these findings, DOE has begun to examine those elements of occupant behavior that most strongly contribute to differences in energy savings as well as the combination of weatherization materials that optimizes energy savings.

Beginning in calendar year 1987, DOE will establish a performance fund from which dollars will be awarded to States meeting its criteria for the best weatherization programs. From 5 to 15 percent of the amount appropriated each year for the DOE program will be used for the fund. Dollars awarded in 1987 will come from the fiscal year 1986 appropriation. The award criteria relates to the percentage of eligible dwelling units within a State that have been weatherized, energy savings resulting from weatherization activities, and the State's actual achievement of its weatherization assistance program goals.[8]

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[7] U.S. Department of Energy. Energy Information Administration. Office of Energy and End Use. Weatherization Program Evaluation. SR-EEUD-84-1. August 20, 1984. Executive Summary and pp. 1-2, 18-19.

## B. ISSUES

### 1. EVALUATING ENERGY ASSISTANCE AND SAVINGS

Of primary concern to the Special Committee on Aging is the effectiveness of energy assistance programs in serving older persons. Both LIHEAP and the Weatherization Assistance Program require that elderly and handicapped citizens be given priority in receiving assistance, to assure that these households are aware that help is available, and to minimize the danger of unnecessary shutoff of utility services. Specific data on the number of older beneficiaries continues to be unavailable. Changes to the law relaxed many of the reporting requirements, and, as a result, many States opted to no longer maintain age-specific data. Although States have come up with a variety of means for implementing the targeting requirement, several aging organizations have suggested that Older Americans Act programs, especially senior centers, be utilized as information and outreach bases for the programs. Discussions with area agencies on aging and senior center staff indicate that increased effort has been made in recent years to identify eligible elderly persons for energy assistance, and to provide the general elderly population with information regarding the risks of hypothermia.

The effectiveness of LIHEAP and the DOE weatherization program continues to be a debated issue. Many argue that the programs have been well directed to the neediest, yet conclusive data is not available.

Proponents of LIHEAP cite continuing need for low-income assistance. Home energy prices continue to be high. Although home heating oil prices have decreased 22 cents per gallon since 1981 (as of August 1985), they have not receded to their pre-1979 levels. In addition, prices for natural gas have risen significantly in the 1980's, with some recent decrease. The consumer price index for household fuel rose 32.6 percent between December 1981 and December 1985.

The Department of Energy's Residential Energy Consumption Survey consistently reports that low-income households spend a greater and increasing portion of their incomes on home energy than other households. In fiscal year 1982, for example, over 50 percent of the households receiving energy assistance had incomes below $6,000. (The 1982 poverty line for a four-person family was $9,862.) About 40 percent of the households receiving energy assistance had a member 65 years of age or older. The President's fiscal year 1985 budget justification for LIHEAP reported that, since fiscal year 1982, the program annually has provided an average of about $200 in benefits to 7 million households (heating assistance only).

LIHEAP however, has had its critics. Those opposed to LIHEAP generally take one of two positions. One position argues that the public welfare system, excluding LIHEAP, is already either sufficient or too generous. Another position is that assistance is needed, but not in the form provided by LIHEAP.

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[8] Federal Register. Part V. Department of Energy. December 5, 1985. 49912. pp. 49912.

Those who oppose specific energy aid for low-income individuals contend that, when combined with other welfare benefits, LIHEAP increases work disincentives, unnecessarily increases the Federal deficit, and makes the cumulative benefits under all welfare programs too generous (especially since LIHEAP benefits are not counted as income for determining eligibility and benefit levels under other means-tested assistance programs). It is also argued that LIHEAP was intended to be only a temporary emergency measure, designed to help households cope with the energy price shocks of the 1970's, and should not become part of the permanent public welfare system.

Among those who favor energy-related aid for those with low incomes, but not in the manner of LIHEAP, there are two principle schools of thought. Some maintain that assistance would be more efficiently provided through the more established means-tested programs such as AFDC, SSI or food stamps. Others argue that LIHEAP, by increasing household income available for energy, discourage energy conservation. The twin goals of helping low-income households meet high energy costs and encouraging energy conservation would be better achieved, some assert, through home weatherization or renewable energy home improvements. It also is argued that LIHEAP benefits often do not make low-income households any better off. Instead, in many areas, benefits are paid directly to utility companies, reducing what would otherwise be bad debts. It should be noted, however, that there is no strong evidence that a significant portion of those receiving LIHEAP benefits would not have paid their fuel bills in the absence of LIHEAP.

Various studies have attempted to quantify energy savings resulting from Federal weatherization efforts. According to the GAO, it is difficult to measure such savings due to differing conditions of dwelling units and varying climatic conditions and fuel prices throughout the country. Additionally, little or no effort has been made to verify the accuracy of fuel-use records in homes that have been weatherized. Experts in this area have noted that most studies do not use control groups where fuel costs in homes weatherized are compared with fuel costs in homes not weatherized. Lacking a control group, it is difficult to accurately predict whether changes in energy consumption are due entirely to weatherization assistance, or in part to changes in fuel prices, conservation programs, appeals from political leaders, or some combination of these. Further, it has been observed by program personnel that some households may conserve less after weatherization because they raise their thermostats to a more comfortable level.

According to GAO, the extent to which DOE's program is reducing energy costs and consumption is unknown by DOE and the States which administer the DOE program. While DOE has claimed a 20- to 25-percent annual energy savings in homes weatherized through its program, GAO reports that this statistic has questionable reliability because of DOE's sampling and data problems.[9]

A study conducted in the State of Minnesota on its weatherization program employed a more scientific methodology to evaluate energy savings. Based on an analysis of fuel records from both weatherized and nonweatherized homes, the study concluded the the DOE program was successful in reducing energy consumption, on average, by 13 percent. The study also concluded that the cost of weatherization is likely to be repaid in terms of lower fuel bills within 3½ years.[10]

Although this evaluation initially showed promise for a careful examination of energy savings, the GAO reported that the study was too geographically limited to reveal savings on a nationwide basis. In the final analysis, GAO has concluded that there is no nationwide study on cost savings which incorporates standardized statistical methods in a way to assure maximum reliability. However, the evaluation discussed earlier in this chapter under the DOE weatherization program description was conducted after GAO's analysis, and provides further evidence that the program is working.

### 2. Block Grant Versus Categorical Funding

Another issue under consideration regarding the energy assistance programs concerns the issue of block grants versus categorical grants in the Federal weatherization program. Many public officials agree that the Federal Government should support weatherization activities for low-income households. The nature of this support, however, is somewhat controversial. While some groups favor the block grant approach to Federal assistance, others find more merit in the categorical grant approach like the DOE program.

For fiscal year 1986, the President recommended phasing out the DOE program, which would leave the LIHEAP block grant as the primary source for federally funded weatherization assistance. Congress, however, did not act on the President's recommendation, and funded the program in fiscal year 1986 at nearly its fiscal year 1985 funding level ($191.1 million). The General Accounting Office reviewed the program and found that priority for weatherization is lower in the block grant programs, which could result in fewer homes being weatherized. GAO noted that a lack of restriction on how funds may be used could result in communities not effectively targeting funds to address the greatest need. Additionally, GAO stated that no evidence existed to support the notion of reduced costs and improved quality under the block grant approach.

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[9] U.S. Government Accounting Office. Uncertain Quality, Energy, Savings and Future Production Hamper the Weatherization Program; Report to the Congress by the Comptroller General of the United States. EMB 82-2. October 26, 1982. Washington, 1982. pp. 18–20.

[10] Hirst, Eric and Raj Talwar. "Reducing Energy Consumption in Low-Income Homes." Evaluation of the Weatherization Program in Minnesota. Evaluation Review, V.5, October 1981. pp. 671–683.

## C. RESPONSES

### 1. LEGISLATION

Despite efforts by the Reagan administration to block grant LIHEAP and eliminate or phase-out the weatherization program, Congress has steadfastly resisted changes. For example, in the 1984 budget request, the Reagan administration proposed replacing LIHEAP with a block grant to States, and requested no funding for the Weatherization Assistance Program. It also proposed to dismantle the Department of Energy. Although Congress studied numerous energy assistance proposals, it rejected the administration's approach and continued the program at essentially the same as during fiscal year 1983.

#### (A) LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

The President's fiscal year 1985 budget recommended that Congress reauthorize LIHEAP through fiscal year 1989 with an annual authorization of only $1.875 billion, which was equal to the fiscal year 1984 authorization, but $200 million below the fiscal year 1984 appropriation. In addition, the administration proposed funding the program from the petroleum overcharge restitution fund [PORF] as opposed to general revenues. (The PORF is the result of oil settlements collected by the Federal Government through litigation against oil companies involved in price gouging in the early seventies.) The Senate and House of Representatives again rejected the administration's proposal, and instead, reauthorized the LIHEAP as part of the Human Services Reauthorization Act [Public Law 98-558]. The law extended the program for 2 additional years at a level of $2.14 billion in fiscal year 1985 and $2.27 billion in fiscal year 1986. In addition, the law revised the formula for determining State allotments under the act to consider the percentage of expenditures for home energy by low-income households in that State in relation to the expenditures in all States. However, Public Law 98-619 (H.R. 6028) reduced the fiscal year 1985 LIHEAP appropriation to $2.1 billion. In fiscal year 1986, the Reagan administration refrained from attempting to cut LIHEAP; Public Law 99-178 appropriated $2.1 billion for LIHEAP. This was $75,000 less than the administration requested.

#### (B) WEATHERIZATION

In his fiscal year 1986 budget request to Congress, the President recommended a $152.9 million funding level for the DOE weatherization program with a plan to phase out the program over a 5-year period. The President also recommended helping States develop strategies for conducting weatherization activities without Federal assistance during the phase out period. In response to this recommendation, DOE began to help States with techniques for carrying out weatherization activities without Federal funds and awarded 38 "opportunity grants" ranging from $40,000 to $60,000 each to State and local agencies for demonstrating strategies to weatherize homes with non-Federal funds. Congress, however, has not acted on the President's request to phase out the program. The DOE Weatherization Assistance Program is operating under a continuing resolution at $190.1 million, just below its fiscal year 1985 funding level of $191.1 million.

## 2. OTHER AGING COMMITTEE ACTIVITIES

During the past 5 years, the Senate Special Committee on Aging has conducted hearings on Federal, State, and local conservation programs and their effect on low-income elderly households. The committee has focused on methods to increase the energy savings benefit of these programs and their cost-effectiveness to the taxpayer. These hearings have resulted in significant improvement in these programs.

In recent years, the Senate Special Committee on Aging and the Alliance to Save Energy have worked together to determine ways to help elderly households better afford energy costs. The Alliance is a nonprofit coalition of business, labor, government, and consumer leaders that promote greater energy efficiency through research, demonstration projects, policy advocacy, and public education. The chairman of the Aging Committee, Senator John Heinz, is a co-chairman of the Alliance; Senator Dan Evans, a member of the committee, serves as its chairman; and Senator J. Bennett Johnston, a committee member, also is a co-chairman of the Alliance.

The Aging Committee's April 1981 hearings contributed to a program change in LIHEAP which now allows States to set aside up to 15 percent of their fuel asistance dollars for energy conservation in low-income and elderly households. In a recent analysis for the U.S. Department of Health and Human Service's Office of Energy Assistance, the Alliance to Save Energy found that, nationwide, this program change resulted in $200 million per year in additional energy conservation investments. That report, which was based on discussions with 50 State program administrators, indicated that when given flexibility, State officials see conservation as an important, long-term answer to energy cost problems.

Although a significant amount of State funds are dedicated to energy efficiency, the report found that over $100 million in possible investments are not being made. Many State officials indicate that although they would prefer to invest the full 15-percent set-aside in conservation, the demand for emergency fuel assistance is so overwhelming they must use the remaining $100 million for assistance payments. This problem is especially acute in those States with the coldest climates and the largest low-income populations where the need for energy conservation in home heating is the most severe.

Once States were given the flexibility to use energy assistance funds for home conservation improvements, a wide variety of innovative approaches were used. One of the most successful of the new approaches was energy retrofit of home heating systems. Traditionally, low-income conservation programs have made improvements to homes by installing weatherstripping, insulation, and storm windows. However, additional energy savings can be realized by improving the efficiency of heating systems.

In April 1983, Senator John Heinz conducted a briefing on heating system retrofit technologies and their potential to increase energy cost savings in elderly households. This briefing was followed by committee hearing in March 1984 which highlighted needed changes in the Department of Energy's Weatherization Assistance Program. At this hearing, State low-income conservation officials testified that numerous technical improvements in the program were needed.

Based on the efforts by committee members and the outcome of the March hearing, as well as an oversight hearing by the Senate Energy Committee, a number of improvements to the DOE weatherization program were enacted as part of the Human Services Reauthorization Act of 1984 (Public Law 98-558). Under this bill, the Energy Conservation in Existing Buildings Act of 1976 was amended to make a number of changes including, among other things, revisions in eligibility levels based on eligibility criterion set forth under the LIHEAP, inclusion of heating system improvements as eligible activities under the program, funds available for investment in each elderly household were raised to an average of $1,600, and inclusion of the aforementioned performance fund to reward States that demonstrate increased efficiencies in carrying out their weatherization program.

In support of these changes, the Alliance to Save Energy entered into a cooperative agreement with the Office of Weatherization Assistance and the Office of Buildings and Community Systems at the Department of Energy, to assist State low-income energy offices. The Alliance provides State conservation offices with training and technical assistance in heating system improvements and in the most cost effective investment of program funds. During the past 2 years, the Alliance has helped States create 26 oil and gas heating system improvement programs. States have committed $20 million to these programs and have now improved 16,000 heating systems, with another 5,000 planned for the near future. The program has also trained 2,500 heating contractors in advanced technology areas.

The Alliance also is helping communities develop "warm room" space heating programs which help elderly people afford to remain in their homes. Preliminary work in electrical system cooling improvement is under way, the goal being cost reductions for elderly people who must cool their homes for comfort or health reasons. Finally, the Alliance, working with Oak Ridge National Laboratory, is developing and field testing a new energy audit system which will help community groups, utilities, and home improvement contractors decide which type of conservation measures are the most cost-effective to install.

## D. PROGNOSIS

There is clear evidence that Federal energy assistance programs have been successful in providing emergency relief and basic energy needs to millions of elderly and poor Americans. These programs have also reduced the energy expenditures for many of the poor through weatherization assistance. The level of the programs' success and their philosophical appropriateness, however, continue to be debated.

Nonetheless, the energy expenses of the elderly and poor will continue to grow during the next decade, creating a wider gap between their need and the Federal Government's response. According to the Community Action Foundation (CAF), 4 million households had utility service terminated for nonpayment in 1982. To prevent service terminations from increasing and to keep the percentage of real income devoted to energy by the poor at a manageable level, billions of dollars in assistance will be needed. CAF estimates that if energy costs grow 2 percent per year, the eligible population would need $7.3 billion in 1989, just to keep purchasing power constant.

The Alliance to Save Energy has demonstrated that cost-effective, low-income conservation programs are possible through installation of new heating system technologies. The development and field testing of much of the new heating system technologies was supported through Federal research and development efforts. Funding for these research activities has been decreasing in recent years, even though these investments in research could result in saving elderly households millions of dollars in energy costs. The availability of research funds will play an important role in determining future conservation successes.

In the past 2 years, many regulated gas and electric utilities have been required by their State public utility commissions to undertake low-income and elderly conservation programs. This new development may have a positive effect on the energy conservation needs of all elderly persons. This approach encourages greater State and local control and funding of such conservation activities.

It is obvious to those who know the administration's philosophy regarding domestic spending and the current mood in Congress, that appropriations at levels to meet eligibility and research needs will not be forthcoming. In fact, it is probable that both LIHEAP and the DOE Weatherization Assistance Program will be targeted again in fiscal year 1987 by either the administration or Members of Congress for cuts or elimination. Continued congressional support and expanded private efforts will be needed to preserve the current minimal level of assistance available to those who lack the means to meet their basic energy requirements.

It is unclear at this time what the impact of falling oil prices will have on consumers of home heating fuels, but fuel oil and electricity costs to consumers continued to rise in 1985. It is possible, however, that some LIHEAP and DOE Weatherization Assistance beneficiaries will need less assistance if prices fall substantially. On the other hand, reductions in heating costs may simply allow these Federal resources to provide energy and conservation to more of the millions of low-income households that are eligible, but remain unserved.

# Part V

## SOCIAL SERVICES

Federal programs support a broad range of services to older Americans, including senior centers, home health programs, counseling and case management, legal services, employment, education, investigation of complaints by residents of nursing homes and board and care facilities, and volunteer opportunities. In contrast to the entitlement programs—Social Security, Medicare, Medicaid, and food stamps—these programs are funded by discretionary appropriations from general revenues. Discretionary programs constitute a miniscule portion of the Federal budget devoted to older Americans. Moreover, in the past 5 years, some of these programs have experienced level funding or substantial reductions as they have been folded into block grants. Others have been the target for total elimination.

The Federal commitment to social services for older Americans is uncertain. The growing congressional and national mood of fiscal austerity, coupled with increasing pressures from large Federal deficits, have begun to redirect national priorities away from federally supported social services and toward a renewed reliance on State, local, individual, and private programs. This trend toward a New Federalism in the social services is expected to grow.

# Chapter 11

# OLDER AMERICANS ACT

## OVERVIEW

Since its enactment, the Older Americans Act (OAA) has evolved from a program of small grants and research projects to a network of 57 States units of aging, over 660 area agencies on aging, and approximately 15,000 community organizations providing supportive social and nutritional services to older adults. At the same time, appropriations for programs under the act have increased from $6.5 million in fiscal year 1966 to over $1 billion during fiscal years 1985 and 1986.

Congress has reaffirmed its support for programs under the Older Americans Act on 10 occasions through passage of various reauthorization bills. The most recent amendments to the act occurred during the 1984 fiscal year. Responding to time pressure prior to adjournment, as well as a pervasive feeling that Older Americans Act programs were operating effectively, Congress made only minor adjustments to the act. The new amendments to the act were signed into law by President Reagan on October 9, 1984. [Public Law 98-459] (For a full discussion of the 1984 amendments, see Developments in Aging; 1984, vol. 1.)

Fiscal year 1985 was legislatively uneventful for the Older Americans Act. Nonetheless, the goal of improving the lives of older Americans through the OAA and its array of services and research, continues to attract strong bipartisan support in Congress. This was reflected in increased appropriations for OAA programs again for fiscal year 1986.

There is, however, growing concern from many OAA advocates, both service providers and recipients, that recent deficit reduction actions are a sign that very few programs will escape the budget cutting axe in the months and years ahead. Program cuts could result in pressure to prioritize titles and programs within the OAA. However, the close link between OAA dollars and direct services that millions of older Americans receive may help to protect OAA funding.

## A. BACKGROUND

### 1. History of the Older Americans Act

For the past 20 years, the Older Americans Act has served as the cornerstone of Federal involvement in a wide array of community services to older persons. Created during a time of rising societal concern for the needs of the poor, the act marked the beginning of a categorical approach to programs specifically designed to meet the social and human needs of the elderly. The act itself was one of a series of Federal initiatives that were part of President Johnson's Great Society programs. These legislative initiatives grew out of a concern for the large percentage of older Americans who were impoverished, and a belief that greater Federal involvement was needed beyond the income transfer and health programs. Although older persons could receive services under a multiplicity of other Federal programs, the act became the first major vehicle for the organization and delivery of community-based social services to the elderly.

The Older Americans Act followed on the heels of a similar but somewhat more expansive grouping of social service programs initiated under the Economic Opportunity Act of 1964. With a similar conceptual framework to that embodied in the Economic Opportunity Act, the Older Americans Act was established on the premise that decentralization of authority and the use of local control over policy and program decisions would create a more responsive service system at the community level.

When first enacted in 1965, the OAA established a series of broad policy objectives designed to meet the needs of older persons. These objectives, however, lacked both legislative authority and adequate appropriations to be truly effective. Despite its limited scope and funding—providing for a Federal Administration on Aging and making minimal grants to State units on aging—the act established a structure through which the Congress would later expand aging services.

Funding for the OAA grew slowly during the 1960's, but during the 1970's Congress followed up on improvements in income transfer programs with significant modifications in services to the elderly. In 1973, for instance, Congress enacted significant expansions in services provided under the Older Americans Act to provide for the establishment of area agencies on aging, and in 1974, created the national nutrition program for the elderly. Fiscal years 1978 and 1980 saw further improvements in the level of financial support directed toward Older Americans Act programs the development of the structures (area agencies on aging [AAA's]) for providing community-based services, and the added emphasis on the provision of certain priority services—access, in-home, and legal services.

This expansion trend continued until the early 1980's when in response to the Reagan administration's policies to cut the size and scope of many Federal programs, the growth of overall OAA spending was slowed and, for some programs, was reversed. Major budget cutting emphasis during this time, however, was placed on reductions in the income transfer and health programs (i.e., Medicare and Medicaid). The focus on the larger money items helped deflect budget cutting measures aimed at programs such as the Older Americans Act, although they were not entirely untouched. For example, between fiscal years 1981 and 1982, title IV funding for training, research, and discretionary programs in aging was reduced by approximately 50 percent. In addition, appropriations for title III, supportive services and congregate and home-delivered meals (excluding the U.S. Department of Agriculture program), declined slightly from 1981 to 1982, from $624.7 million to $606.6 million. Since 1983, funding has increased at a rate less than the rate of inflation. Nevertheless, widespread congressional support for other OAA programs, especially nutrition and senior employment, served to protect them.

Congress has rejected some Reagan administration proposals for reductions in Older Americans Act programs in various budget submissions since 1981, most notably the administration's attempt in fiscal year 1983 to eliminate the community service employment progam under title V. Congress has also rejected Administration proposals to consolidate appropriations for the supportive services, and congregate and home-delivered nutrition service components under Title III, and to transfer the U.S. Department of Agriculture [USDA] commodity program from the Department of Agriculture to the Administration on Aging (AoA). (The 1986 budget submission did not contain proposals to consoliate title III services or to transfer the commodity program to AoA.) With respect to the title IV research, training, and demonstration program, the administration's fiscal year 1986 budget reduction request of $12.5 million was a more moderate reduction request than in previous years. In fiscal year 1984 and fiscal year 1985 the request for this program was $5 million.

Despite administration efforts, OAA progams were spared funding reductions experienced by other social services programs. Total OAA programs grew from $1.035 billion in 1981 to $1.144 billion in 1985, an overall increase of 10 percent for the period. Table 1 shows that appropriations for the period fiscal year 1980–1986 increased from $988 million to $1.165 billion in fiscal year 1986, an overall increase of almost 18 percent.

*Table 1.—Older Americans Act appropriations, 1980–86* [1]

[Dollars in thousands]

| Fiscal year | *Appropriation* |
|---|---|
| 1980 | $988 |
| 1981 | 1,035 |
| 1982 | 1,007 |
| 1983 | 1,107 |
| 1984 | 1,123 |
| 1985 | 1,144 |
| 1986 | 1,165 |

[1] Includes all programs.

Over the years, the essential mission of the Older Americans Act has remained very much the same: Provide a wide array of social and community services to those older persons in the greatest economic and social need in order to foster maximum independence. The key element in the program has been to help maintain and support older persons in their homes and communities to avoid unnecessary and costly institutionalization.

States and area agencies on aging constitute the administrative structure for programs under the act. In addition to funding specific services, they have broad responsibilities to act as advocates on behalf of older persons and to plan for the effective development of a service system that will best meet these needs. Beyond this mission, and as originally conceived by the Congress, this system was meant to encompass both services funded under the act, and services supported by other Federal, State, and local programs. The concept of resources mobilization and coordination was an important element in the early development of the act.

## 2. The Older Americans Act Amendments of 1984

The following is a brief description of each title of the Older Americans Act as amended in 1984.

### (A) DECLARATION OF OBJECTIVES—TITLE I

Title I sets forth the national objectives for older Americans particularly for improving their income, health, housing, and community services opportunities.

### (B) ADMINISTRATION ON AGING AND FEDERAL COUNCIL ON AGING—TITLE II

Title II establishes the Administration on Aging [AoA] within the Department of Health and Human Services [DHHS] and the Federal Council on Aging. The Council was first authorized in the 1973 amendments to the act. Federal Council appropriations reached their height in fiscal year 1976 and declined for most years since that time.

### (C) GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING—TITLE III

Title III authorizes grants to State agencies on aging to develop a comprehensive and coordinated delivery system for supportive services, nutrition services, and multipurpose senior centers for older persons. This system is intended to assist older persons attain maximum independence in a home environment, to remove individual and social barriers to economic and personal independence, and to provide services and care for the vulnerable elderly. Since original passage of the act in 1965, the title III program has evolved from simply a funding source for social service programs to a planning vehicle for development of a comprehensive and coordinated service system for older persons with funding authority for a broad range of supportive services, nutrition services, and multipurpose senior centers. Significant amendments in 1969, 1973, and 1978 broadened the scope of operations and established the basis for a "network" on aging under the title III program umbrella.

The title III nutrition service component, providing for congregate and home-delivered meals, is one of the most visible federally funded social service programs for older persons, and represents about 46 percent of total Older Americans Act funds in fiscal year 1986, including the elderly commodity program. The supportive service component, which funds a variety of social services, such as ombudsman, in-home, legal, and access services, represented about 23 percent of the act's total fiscal year 1986 funding.

Funds for State administration, supportive services and senior centers, congregate and home-delivered nutrition services are allotted to State agencies on aging based on the State's share of the 60 and over population as compared to all States, with minimum amounts for the territories. State agencies, in turn, award funds to area agencies on aging for administration within specified planning and service areas. Area agencies provide funds to agencies and organizations for the delivery of a wide range of supportive services (with special emphasis on access, in-home, and legal services), and congregate and home-delivered nutrition services. The law requires that preference be given to serving older persons with the greatest social or economic needs with particular attention to low-income minority older persons. Means tests as a criterion for participation are prohibited.

State agencies on aging also receive U.S. Department of Agriculture [USDA] commodities or cash in lieu of commodities, to supplement the costs of providing meals under title III. The law requires the USDA to provide State agencies an annually programmed level of assistance that is based on the number of meals served with title III funds. The USDA reimbursement is provided on a per meal basis in an amount adjusted for inflation to reflect changes in the Consumer Price Index for Food Away from Home. While the law provides for the distribution of commodities, most States have opted to receive a combination of cash in lieu of commodities as well as commodities to supplement meals provided under the title III program.

Appropriations for title III services and State administration increased by 13 percent for the period 1980–85 (excluding amounts for USDA commodities). Athough Congress appropriated specific amounts for supportive services, and congregate and home-delivered nutrition services, the act allows States to transfer funds between these separate categories. The 1984 amendments to the act increased the ability of States to transfer funds between these separate amounts. The 1984 amendments allow a State to transfer up to 27 percent of its alloted funds for supportive services and nutrition services between these service categories in fiscal year 1985, up to 29 percent in fiscal year 1986, and up to 30 percent in fiscal year 1987. In addition, the act allows States to transfer funds between the congregate and home-delivered nutrition service categories. In recent years States have increasingly shifted funds between these three separately appropriated amounts, with a notable shift of funds from the congregate nutrition program to other service components. For example, in fiscal year 1984, $41 million was transferred from the congregate nutrition appropriation to other title III services. The 1984 amendments also changed the manner in which funds for the State administration are made to States by consolidating funds for this purpose under the title III services amounts. Since fiscal year 1985, States do not receive a separate allocation of funds for State administration, but are allowed to use up 5 percent of their allocation for title III services or $300,000, whichever is greater, for administration.

According to data reported by States to AoA, the number of supportive service participants has remained virtually the same for the period 1980–84, at approximately 9 million participants each year. The number of meals served, supported by title III as well as other funds available under auspices of the program, increased 35 percent from 167 million in fiscal year 1980 to over 225 million in fiscal year 1985.

### (D) TRAINING, RESEARCH, AND DISCRETIONARY PROJECTS AND PROGRAMS—TITLE IV

Title IV of the act authorizes appropriations for training, research, and demonstration programs in the field of aging. Under the training authority, the Commissioner on Aging is required to award grants or enter into contracts for activities related to the recruitment of personnel, inservice training for those employed in aging services, and technical assistance activities. It also authorized grants for multidisciplinary centers of gerontology.

Under the research authority, the Commissioner may support a wide range of projects related to the purpose of the act as well as conduct evaluation activities.

Under the demonstration authority, the Commissioner is authorized to conduct model projects to demonstrate methods of improving or expanding supportive or nutrition services or other services to promote the well-being of older persons. The Commissioner is required to give special consideration to certain projects such as those designed to meet the special needs of the rural elderly and supportive service needs of persons with Alzheimer's disease and other neurological and organic brain disorders.

The Commissioner is required to conduct demonstration projects relating to legal services for older persons. In addition, the Commissioner is authorized to conduct special demonstrations in comprehensive long-term care, projects which would relieve the excessive burdens of high utility and home heating costs, and other projects having national significance.

Appropriations for title IV reached their height in fiscal year 1980 at a level of $54.3 million. This program has experienced the greatest reduction of any Older Americans Act program in recent years, with a decline of 59 percent from the fiscal year 1980 level of $54.3 million to $22.2 million in fiscal year 1982. Appropriations remained at that level in fiscal year 1983 and fiscal year 1984, and increased slightly to $25 million in fiscal year 1985 where they remained for fiscal year 1986. The title IV fiscal year 1985 funding level represents about 2 percent of total Older Americans Act funds. In fiscal year 1985 the program supported 200 grants and contracts. In 1984, an estimated 31,500 students were trained in academic aging programs and 241,000 State and area agency and service provider personnel received inservice training.

### (E) COMMUNITY SERVICE EMPLOYMENT PROGRAM FOR OLDER AMERICANS—TITLE V

The program's purpose is to subsidize part-time community service jobs for unemployed persons aged 55 and over who have low incomes. The basis for the current program was a demonstration program created during the 1960's under the Economic Opportunity Act [EOA]. Modeled after Operation Mainstream, a pilot project authorized under title II of the EOA, it was first funded in 1965. In 1967, administrative responsibility for Operation Mainstream was transferred from the Office of Economic Opportuity to the Department of Labor [DOL] but funding authority continued under the EOA. In 1973 the program was given a statutory basis under the Older Americans Act amendments. The program continues to be administered by DOL, which awards funds to national organizations and to State agencies to operate the program. (Except for the elderly commodity program, other Older Americans Act programs are administered by DHHS.)

The program has seen steady increases in funding and participant enrollment since its inception. In 1974, the first year the program received an appropriation under the Older Americans Act, participant enrollment was 3,800 with an appropriation of $10 million. Appropriations for fiscal year 1985 and fiscal year 1986 of $326 million are estimated to support about 63,800 employment positions (to cover the period July 1985–June 1986). (Note: the program is funded on a "forward-funded" basis; that is, funds appropriated for a given fiscal year are to be used beginning on July 1 of that fiscal year and ending on June 30 of the following year.)

Although persons 55 years or older are eligible for the program, priority is to be given to placing persons 60 years or older in community service jobs. Their income must not exceed 125 percent of the poverty level guidelines issued by DHHS (in 1986, $6,700 for a 1-person household). Enrollees are paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, whichever is higher. Participants may work up to 1,300 hours per year and average 20–25 hours per week. For the 1984–85 program year the average hourly wage paid to enrollees was $3.46. In addition to wages, enrollees receive annual physical examinations, personal and job-related counseling, and some job training.

Participants work in a wide variety of community service activities. In the 1984–85 program year, about 60 percent of job placements were in the services to the general community while over 40 percent were in services to the elderly. The program provides substantial support to nutrition programs for the elderly, primarily funded under title III of the Older American Act and administered by State and area agencies on aging. About 10.5 percent of the employment opportunities in title V aging services placements were in nutrition services. Other job areas in aging services were in recreation/senior centers and outreach and referral services. In services to the general community, enrollees were placed primarily in education and social service activities.

Funds are allocated to national organizations and to State agencies on aging. National organizations that receive funds are Green Thumb; American Association of Retired Persons; U.S. Department of Agriculture's Forest Service; National Caucus and Center on Black Aged, Inc.; Association Nacional Pro Personas Mayores; and the National Urban League. In allotting funds DOL is required to reserve a "hold harmless " amount to enable the national organizations to maintain their 1978 level of activities. No more than 45 percent of funds exceeding the 1978 level of appropriations is to be awarded to national organizations and allocated among States according to a formula which takes into account the number of persons 55 years of age and over and per capita income. The remainder of funds in excess of the 1978 level of appropriations is to be distributed to State agencies on aging according to the same formula. In addition to this formula-distribution requirement in the Older Americans Act, appropriations legislation has contained requirements regarding the distribution of funds to national organizations and States. Appropriations language has required that national organizations receive 78 percent of funds and State agencies receive 22 percent.

#### (F) GRANTS FOR INDIAN TRIBES—TITLE VI

The purpose of the title VI program is to promote the delivery of supportive and nutrition services to older Indians which are comparable to services offered to other older persons under title III. The program received its first appropriation in fiscal year 1980. In fiscal year 1985, awards were made to 120 tribal organziations.

#### (G) OLDER AMERICANS PERSONAL HEALTH EDUCATION AND TRAINING PROGRAM—TITLE VII

The 1984 amendments added a new title to the act which required the Secretary of Health and Human Services, through AoA, to award funds to institutions of higher education to design and implement standardized health education and training programs for older persons. No funds were appropriated for fiscal year 1985, requested for fiscal year 1986, or appropriated for fiscal year 1986.

## B. ISSUES

### 1. Targeting of Services

A major issue that will continue to be debated in the coming years, especially in light of the large deficits, is whether the OAA should be amended to focus more narrowly on certain subgroups of older persons. During 1984 reauthorization hearings on the act, some witnesses suggested that, in view of the limited resources available under the program and the special needs of certain groups of older persons, the act should be targeted to such groups.

Congress has resisted targeting in the past. Title III, for example, currently requires that preference in providing supportive and nutrition services be given to those older persons with the greatest economic or social needs. Despite this, and regulations which require that special attention be given to certain economic and ethnic groups, the distribution of title III funds to States is based solely on the number of older persons in the State. In fact, Congress has prohibited use of a means test for determining eligibility for title III services, and has always maintained that the act is open to all older persons in need of services. In addition, States are required to distribute funds according to a formula taking into account the geographical distribution of persons 60 years and over. AoA regulations require the State's intrastate funding formula to reflect the proportion among the planning and service areas of older persons with the greatest economic or social needs.

During the first session of the 98th Congress, the Senate Labor Committee's Subcommittee on Aging held a hearing on the issue of targeting resources based on economic or social need. Testimony ranged from those who claim the current legislation provides sufficient flexibility for State and local agencies to serve targeted groups, to those who support specific set-asides to minorities, Indians, and other limited English-speaking individuals. One witness expressed the view that targeting be based on the concept of functional capacities of older persons.

In response to these concerns, the 1984 amendments made two changes designed to strengthen the greatest social and economic need provision. First, the amendments required States to publish a more detailed disclosure statement on their funding formula. In making this change, the Senate Committee on Labor and Human Resources noted:

> This requirement is intended to increase public knowledge of how a State agency has planned to distribute all resources made available under the act and to target resources to specific groups of older persons, as well as to increase State accountability for its funding decisions.[1]

The second change in the law was to require that State and area agencies provide assurances that special attention will be given to older minority persons.

The OAA is one of many domestic programs that will have to fight for its share of the scarce resources available for such programs in the remainder of the 1980's and beyond. The OAA is likely to lose some of its total fiscal year 1986 funds at least until revenues are increased sufficiently to absorb the impact of inflation and the reductions necessary to reach a balanced budget, unless Congress retreats from its most recent position.

This scenario leaves OAA proponents two primary options when faced with fewer dollars: (1) Support reductions in titles and programs in OAA across the board, possibly forcing some programs to become so small as to be unworkable; or (2) support targeting the available resources toward a particular segment or segments of the older population.

The targeting choice is offensive to some OAA advocates from the outset because they believe that the program's popular support and lack of welface stigma result from the broad availability of title III programs. Many believe that a restricted or means-tested title III, designed to target only the very poorest, for example, could sour the national and congressional attitude toward the program. This could lead to further reductions in funding in the future. On the other hand, some contend that only social programs for the very poorest will survive the budget cutting process.

The wide range of goals set forth under the Older Americans Act are not practically achievable with $1 or even $2 billion per year. Therefore, some argue that the programs should focus on a smaller number of needs, and that they should address them more fully. Targeting could direct OAA funding at those who are most in need, but deciding who should select and prioritize the neediest groups and the types of programs to serve them is a much more difficult problem to solve.

The issue of getting the most from our limited dollars toward improving the quality of life for the elderly will be especially important in the coming years. Some will opt for targeting instead of across-the-board reductions. Others will not accept the inevitability of OAA reductions and will continue to strive for the expansion of the program that is necessary for it to fulfill its stated goals.

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[1] U.S. Congress, Senate Committee on Labor and Human Resources. Older Americans Act of 1984. May 18, 1984. Report No. 98-467, p. 11.

### 2. REDUCTIONS IN COMMODITIES PROGRAM REIMBURSEMENTS

As mentioned earlier, under section 311, State agencies on aging receive from the USDA, commodities, or cash in lieu of commodities, to supplement appropriations for congregate and home-delivered nutrition services. Current law requires USDA to provide States an annually programmed level of assistance that is based on the number of congregate and home-delivered meals served under auspices of the title III program. The level of reimbursement is made on a per meal basis in an amount adjusted for inflation to reflect changes in the Consumer Price Index. The 1981 amendments to the Older Americans Act placed, for the first time, an authorization ceiling on the program, and required the Secretary of Agriculture to reduce the per meal reimbursement level in any year in which the cost of the program would exceed the authorized level (that is, would exceed the total of the number of meals served multiplied by the per meal reimbursement level). The 1984 amendments to the act established the following authorizations of appropriations: Fiscal year 1985, $120.8 million; fiscal year 1986, $125.9 million; and fiscal year 1987, $132 million.

Because of the stipulation in the law that the per meal reimbursement rate be reduced when the cost of the program is expected to exceed the authorization level, USDA took action to reduce the rate based on its projections of increased numbers of meals to be served in fiscal year 1985. On February 21, 1985, USDA published a notice in the Federal Register (vol. 50, no. 35, p. 7203) that the per meal reimbursement rate originally estimated for the program for 1985, 58.75 cents, would instead be 56.76 cents. USDA projected that the number of meals to be served during fiscal year 1985 would be 212.8 million, which, if reimbursed at the estimated per meal rate of 58.75 cents would result in a program cost of $125.020 million, $4.22 million over the fiscal year 1985 authorization level of $120.8 million. USDA indicated that the reduced per meal rate of 56.76 cents would keep the cost of the program under the authorization ceiling. Subsequent to the February notice, USDA announced in the August 19 Federal Register (vol. 50, no. 160, p. 33363) that further action to reduce the per meal reimbursement level may be necessary. This announcement was made based on further projected increases in the number of meals to be serve during fiscal year 1985. The August announcement indicated that the number of meals to be served during fiscal year 1985 could range from 220 million to 230 million. To keep the cost of the program within the authorization ceiling specified by the law, USDA stated that the per meal reimbursement rate may ultimately be between 52.52 cents and 54.90 cents. The unofficial number of meals served and reimbursement rate available prior to printing were 225, 293, 379 and 53.61 cents respectively

The uncertainty which these changes in per meal reimbursement rates creates for the States can have a negative impact on the program. States must wait until after the end of the calendar year to find out what reimbursement rate they will receive for meals that they have already provided and reported by the end of December. This creates a situation in which States may hold back on the number of meals they provide until the last quarter of the year.

## C. RESPONSES

### 1. LEGISLATION

#### (A) COMMODITIES PROGRAM

On September 23, 1985, the House Education and Labor Committee reported H.R. 2453 to amend the U.S. Department of Agriculture [USDA] elderly commodity program authorized under section 311 of the act by increasing the authorization of appropriations for fiscal years 1985, 1986, and 1987 (House Report No. 99-286). This bill passed the House on September 24, 1985. On November 19, 1985, Senator Grassley introduced S. 1858, also designed to increase the authorization of appropriations for these fiscal years. This bill was reported by the Committee on Labor and Human Resources on December 17, 1985, and was passed by the Senate on February 5, 1986. The bills are intended to remedy a potential shortfall in the authorized levels for these years.

To guarantee that States would receive a specified reimbursement rate for meals served under auspices of the title III program, H.R. 2453 and S. 1858, would provide for a 56.76 cents per meal reimbursement rate in fiscal year 1985 and fiscal year 1986. The bills differ in that H.R. 2453 would remove the authorization ceilings for the program while S. 1858 would retain, but increase, specific authorization ceilings for fiscal years 1985–87. H.R. 2453 would authorize such sums as may be necessary for all 3 fiscal years; S. 1858 would specify the following authorization ceilings: fiscal year 1985, $127.8 million; fiscal year 1986, $144 million; and fiscal year 1987, $144 million.

In other action on the elderly commodity program during 1985, both the House and the Senate approved appropriations bills for fiscal year 1986. On July 24, 1985, the House approved H.R. 3037, the Agriculture Rural Development, and Related Agencies Appropriation Bill for fiscal year 1986, and included $125.9 million for the elderly commodity program. This level is equivalent to the authorization level for the program under current law. On October 16, the Senate approved its version of H.R. 3037. The Senate would provide $137.8 million for fiscal year 1986, and would make available from this amount up to $7 million to be used to pay for meals served in fiscal year 1985. The Senate Agriculture Appropriations Committee report (No. 99-137) indicated that the committee is taking this action to prevent a reduction in the rate which had been planned and to make up an anticipated shortfall in funds in fiscal year 1985.

H.R. 3037 was never conferenced or sent to the President. Therefore, Congress provided $136.973 million under House Joint Resolution 465, further continuing appropriations for fiscal year 1986, on December 19, 1985. This bill referred to the Senate language which allowed $7 million to be used for fiscal year 1985 meals.

## (B) OLDER AMERICANS ACT FUNDING

The Administration's fiscal year 1986 budget request for all Older Americans Act programs totalled $1.136 billion, as compared to $1.144 billion which was appropriated for fiscal year 1985. For fiscal year 1986 the budget request included $790 million for nutrition services, supportive services and senior centers, and State administration under title III and $326 million for the community service employment program under title V. A reduction of $12.5 million was requested for the training, research, and demonstration programs under title IV, 50 percent less than the $25 million appropriated for fiscal year 1985.

In appropriations action on the Older Americans Act during 1985, Congress approved final appropriations levels for Older American Act programs administered by the Administration on Aging (State and community programs for supportive nutrition services under title III; discretionary training research and demonstration programs under title IV; grants for Indian tribes under title VI; and the Federal Council on Aging under title II), and the Department of Labor (community service employment under title V). This appropriations legislation, signed into law as Public Law 99-178 on December 12, 1985, continued funding for these programs at their 1985 levels, as follows: Federal Council on Aging, $200 million; supportive services and senior centers, $265 million; congregate nutrition services, $336 million; home-delivered nutrition services, $67.9 million; training, research, and discretionary programs, $25 million; community service employment, $326 million; and grants for Indian tribes, $7.5 million.

Fiscal year 1986 continuing appropriations for the U.S. Department of Agriculture elderly commodity program under title III was approved by Congress on December 19, 1985 (H.J. Res. 465). This measure provided for $137 million for the elderly commodity for fiscal year 1986. Table 2 shows the fiscal year 1985 appropriations, the President's fiscal year 1986 request and the fiscal year 1986 appropriations.

TABLE 2.—OLDER AMERICANS ACT—FISCAL YEAR 1985 APPROPRIATIONS FISCAL YEAR 1986 ADMINISTRATION PROPOSALS, AND FISCAL YEAR 1986 APPROPRIATIONS

[Dollars in thousands]

| | Fiscal year— | | |
|---|---|---|---|
| | 1985 appropriation | 1986 administration proposal | 1986 appropriation |
| Title II—Federal Council on Aging | $200 | $200 | $200 |
| Title III: | | | |
| Supportive services and senior centers | 265,000 | 265,000 | 265,000 |
| Nutrition services: | | | |
| Congregate | [1] 336,000 | 336,000 | 336,000 |
| Home-delivered | 67,900 | 67,900 | 67,900 |
| USDA commodities | [2] 116,000 | 120,800 | 136,973 |
| State agency activities | [3] | [3] | [3] |
| Subtotal—Title III | 784,900 | 789,700 | 805,873 |
| Title IV—Training, Research and Discretionary Projects and Programs | 25,000 | 12,500 | 25,000 |

TABLE 2.—OLDER AMERICANS ACT—FISCAL YEAR 1985 APPROPRIATIONS FISCAL YEAR 1986 ADMINISTRATION PROPOSALS, AND FISCAL YEAR 1986 APPROPRIATIONS—Continued

[Dollars in thousands]

| | Fiscal year— | | |
|---|---|---|---|
| | 1985 appropriation | 1986 administration proposal | 1986 appropriation |
| Title V—Community Service Employment | 326,000 | 326,000 | 326,000 |
| Title VI—Grants for Indian Tribes | 7,500 | 7,500 | 7,500 |
| Title VII—Older Americans Personal Health Education and Training Program | 0 | 0 | 0 |
| Total | 1,143,600 | 1,135,900 | 1,164,573 |

[1] The Administration is requesting a rescission of $50,000 from the amount shown.

[2] The budget appendix shows a level of $120.8 million (the amount authorized under Sec. 311 of the Act). According to USDA, an additional $4.8 million is available in FY85 from prior year funding, which when combined with the $116 appropriation, total $120.8 million.

[3] The 1984 amendments (P.L. 98–459) consolidated funds for State administration under amounts appropriated for services. States may use up to 5% of their services allotments or $300,000, whichever is greater, for administration. Prior to 1985, there was a separate amount appropriated for State administration.

## 2. REGULATIONS

During 1985, revised regulations on three titles of the Older Americans Act were issued: The Department of Health and Human Services issued final regulations on the title III and title VI programs and the Department of Labor issued proposed revised regulations governing the title V community service employment program. Title VI interim final regulations were published in the Federal Register with the title III regulations on April 1, 1985, and were finalized on October 11, 1985. They received few comments and were considered noncontroversial. Following is a brief discussion of revised regulations on title III and V.

### (A) REGULATIONS GOVERNING THE STATE AND AREA AGENCY ON AGING PROGRAM (TITLE III)

On April 1, the Administration on Aging, Department of Health and Human Services, published interim final regulation governing title III of the act. These interim final regulations were intended to respond to comments received by the Department on a notice of proposed rulemaking (NPRM) published over 2 years earlier, on March 2, 1983, and to incorporate statutory changes made by provisions of the 1984 amendments to the act. The regulations represent a significantly shortened version of previous regulations governing the title III program which were effective on March 31, 1980. Principles embodied in the 1983 proposal, and which also guided the development of the interim final regulations, included eliminating regulations not serving a compelling Federal interest; emphasizing private market forces, whenever feasible, rather than Government mandate; providing maximum State and local flexibility; minimizing Federal, State, local and private costs; and preventing fraud, abuse, waste, and inefficiency. In addition, the regulations were intended to supplement, not repeat, provisions governing the program contained in the statute, resulting in a significantly shortened version of the regulations as published in 1980.

When the NPRM was published in 1983 there were a number of concerns raised by Members of Congress and other commenters.

The Department indicated in the preamble to the April 1, 1985, regulations that it received approximately 375 letters in response to the NPRM. Issues of concern included the following—removal of specific requirements for State and area agencies in the area of advocacy on behalf of older persons; deletion of requirements for public hearings on State and area plans on aging; deletion of requirement for State and area agencies to establish and support advisory councils; and deletion of certain staffing requirements for State and area agencies, such as requirements for a full-time director and affirmative action. In response to these concerns, the April 1, 1985, interim final regulations made some, but not all, changes pursuant to the comments. The Department added separate sections of the regulations on State and area agency advocacy responsibilities, but added certain caveats to such advocacy activities; required establishment of an area agency advisory council (required by statute), but not a State advisory council (not required by statute); and required "qualified staff" to administer State and area agencies. The regulations did not reinstate requirements for public hearings on State/area plans.

One of the most controversial issues raised by the publication of the April 1, 1985, interim final regulations was new language with respect to State and area agencies' advocacy responsibilities. While the 1983 proposed regulations eliminated references to the statutory advocacy responsibilities of area agencies to act as advocates on behalf of older persons, these requirements were reinserted in the April 1, 1985 interim final regulations in generally the same form, but with a specific disclaimer. (Sections 305 and 306 of the act contain specific requirements that State agencies act as advocates for the elderly by reviewing and commenting on all State plans, budgets, and policies affecting the elderly, and that area agencies serve as advocates and focal points for the elderly within their communities by monitoring, evaluating, and commenting on various community policies.) The disclaimer in the April 1 regulations stated: "No requirements in this section shall be deemed to supersede statutory or other regulatory restrictions regarding lobbying or political advocacy with Federal funds." Some observers indicated that this language not only lacks clarity as to the kinds of allowable or unallowable advocacy activities of State and area agencies, but also may serve to dampen efforts of these agencies to act as advocates. Expressions of concern about this new regulation were made by both the House and Senate. On June 21, Senator Grassley inserted a statement in the Congressional Record (CR, p. 8635–8638) indicating the confusion in the aging policy community about the regulation. On July 25, Congressman Biaggi also inserted a statement in the Record (CR, p. E3548–3551). In his remarks Mr. Biaggi expressed some of the congressional sentiment about this regulation: "The interim final rules do not cite any specific statutes or regulations that limit advocacy activities, nor do the rules indicate the types of advocacy activities that may be restricted. Without further guidance, the aging community is left to question the legality of every advocacy activity contemplated or undertaken by area agencies on aging. This situation encourages an unnecessarily cautious approach by area agencies on aging. The fulfillment of congressionally mandated advocacy responsibilities thus can be expected to be hindered by the interim final rules." (CR, July 25, 1985, p. E3549)

The April 1, 1985 regulations carried a 60-day comment period which ended May 31, 1985; however the NPRM indicated that the regulations were effective on May 1. On October 11, 1985, the Department finalized the interim final regulations published in April with the publication of a notice in the Federal Register (FR, vol. 50, No. 198, p. 41514).

### (B) REGULATIONS GOVERNING THE COMMUNITY SERVICE EMPLOYMENT PROGRAM (TITLE V)

On July 19, 1985, the Department of Labor published proposed revised regulations governing the title V program (Federal Register, v. 50, no. 139). These regulations were intended to revise regulations published on March 2, 1976, and to incorporate some of the legislative requirements added by major amendments to the act in 1978, 1981, and 1984. (Proposed revised regulations were published by the Department on March 25, 1980 (Federal Register, v. 45, no. 59), but were never finalized.) Generally, the regulations set forth grant planning and application procedures, requirements for project operations, limitations on Federal funds, and administrative standards and procedures.

The proposed regulations issued in July differ from the 1976 regulations in a number of ways. They include heightened emphasis on transition of title V enrollees into unsubsidized employment by increasing the numerical goal for placement of enrollees into unsubsidized employment. The 1976 regulations set as a goal the transition into unsubsidized employment of an annual percentage of at least 10 percent of project positions. The proposed regulations set the goal at 20 percent. (The proposed 1980 regulations had set the goal at 15 percent.) In addition, the regulations encourage project sponsors to provide additional training to enrollees to assist them in acquiring or improving skills to assist them in finding unsubsidized employment.

Other sections of the proposed regulations allow project sponsors to set time limits on enrollment of participants, under certain circumstances; limit the circumstances under which enrollees may appeal project sponsors' decisions; and, require recertification of income eligibility once a year. Also, in accordance with the 1984 amendments to the act, the regulations set the cost limits for administration of the program at 13.5 percent for the 1986-87 program and 12 percent for the 1987-88 program year.

The regulations carried a 30-day comment period, ending August 19, 1985. The comment period was subsequently extended for a period of 30 days.

## D. PROGNOSIS

Fiscal year 1985 marked the 20th anniversary of the Older Americans Act. With the exception of some 1981-82 program reductions, the act has consistently received increased appropriations despite the Reagan administration's efforts to substantially reduce domestic spending.

The future structure and funding of the Older Americans Act is less promising, however, and must be considered in the context of the Federal Government's current financial crisis and the corresponding budget cutting mood in Congress. For example, the new title VII, Older Americans Personal Health Education and Training Program, has not been funded. It is probable that most domestic programs will be further reduced between fiscal years 1987 and 1990. In the case of the OAA this would be likely to result in the provision of fewer services to the most rapidly growing segment of our population. OAA advocates may, as a result of funding reductions, develop new ways to better focus resources while maintaining the integrity of the OAA approach.

In addition, the upcoming 1987 reauthorization will probably encompass a review of many programmatic issues, including State and area agency on aging initiatives in community-based long-term care and new ways of handling the pressures created by the Medicare prospective reimbursement system. The case management systems (as defined in the 1984 reauthorization) will also be analyzed.

A review of elder abuse prevention, and implementation of the final regulations for 1981 and 1984, is expected. Regulations specifying limitations on the advocacy activities of State and area agencies on aging may become a "hot" issue.

In sum, the Older Americans Act, which has truly become a major social service initiative, has fared well during the past 10 years, but will face close scrutiny in the years ahead.

## Chapter 12

# SOCIAL, COMMUNITY, AND LEGAL SERVICES

## OVERVIEW

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a variety of community and social services including home health programs, legal services, education, transportation, volunteer opportunities for older Americans.

During the Reagan administration, two basic themes have emerged with respect to the delivery of social services for the elderly. First, the administration has sought to give States greater discretion in the administration of social services as part of its "New Federalism" initiatives. Second, the shift toward block grant funding has been accompanied by a general trend toward fiscal restraint and retrenchment. As a result, the competition for scarce resources has been accelerated between the elderly and other needy groups. In addition to the cuts accompanying the block grants, the administration has proposed to reduce spending for education, transportation, and legal services. Fiscal restraint in these programs has affected service delivery in varying degrees, with the most significant cuts coming in legal services, which the administration has sought to eliminate entirely. Older American Volunteer Programs [OAVP], in contrast, have enjoyed strong support from the administration.

For the most part, Congress has resisted the administration's efforts to reduce funding for social, community, and legal services. Following the cuts sustained in the fiscal year 1981 budget, Congress increased spending for the Social Services Block Grants [SSBG], and the Community Services Block Grants [CSBG], and legal services, and in fiscal year 1985, increased significantly authorized spending levels for adult education and other education programs benefitting the elderly. The focus on Federal spending however is now clearly framed by the widespread concern over budget deficits. The resolution of this debate may very well determine the Federal role in providing social services to the elderly in the years ahead.

## A. BLOCK GRANTS

### 1. Background

#### (A) SOCIAL SERVICES BLOCK GRANT

Social services programs are designed to protect individuals from abuse and neglect, help them become self-sufficient, and reduce the need for institutional care. Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash benefits alone would not meet all the needs of the poor. Instead, services were provided and funded largely by State and local governments and private charitable agencies. The Federal Government began funding such programs under the Social Security Act in 1956 when Congress authorized a dollar-for-dollar match of State social services funding. Between 1962 and 1972, the Federal matching amount was increased and several program changes were made to encourage increased State spending. By 1972, a limit was placed on Federal social services spending because of rapidly rising costs. In 1975, a new title XX was added to the Social Security Act which consolidated various Federal social services programs and effectively centralized Federal administration.

Title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded and certain day care services which received 100 percent Federal funds. Training was also matched at a 75 percent Federal rate. Significantly, the law required that at least half of each State's Federal allotment be used for services to recipients of aid to families with dependent children [AFDC], supplemental security income [SSI], or Medicaid. The remaining funds could be used to provide services to anyone whose income did not exceed 115 percent of the State's median income. Fees were mandatory for individuals with incomes between 80 and 115 percent of the State median income. States also were required to follow a specified planning and public participation process.

In 1981, Congress created the social services block grant [SSBG] as part of the Omnibus Budget Reconcilation Act. By eliminating most of the restrictions in title XX, Congress granted the Reagan administration added flexibility to transfer maximum decision-making authority to the States. Under the SSBG, States are no longer required to provide a minimum level of services to AFDC, SSI, or Medicaid recipients, nor are Federal income eligibility limits imposed. Non-Federal matching requirements were eliminated, and Federal standards for services, particularly for child day care, also were dropped. The SSBG allow States to design their own mix of services and to establish their own eligiblity requirements.

### (B) COMMUNITY SERVICES BLOCK GRANT

The community services block grant [CSBG] is the current version of the Community Action Program [CAP], which was the centerpiece of the war on poverty of the 1960's. This program originally was adminsitered by the Office of Economnic Opportunity [OEO], a component of the executive Office of the President. In 1975, OEO was renamed the Community Services Administration [CSA] and reestablished as an independent, executive branch agency.

As the cornerstone of OEO/CSA antipoverty activities, the Community Action Program gave basic seed grants to local, private nonprofit or public organization designated as the official antipoverty agency for a community. These community action agencies

[CAA's] were directed to provide services and activities having a measurable and potentially major impact on the causes of poverty. During the 17-year history of OEO/CSA, numerous antipoverty programs were initated and spun off to other Federal agencies, including Head Start, Legal Services, low-income energy assistance and weatherization. The OEO budget peaked in fiscal year 1969 and 1970 with an annual funding of $1.9 billion. The funding then steadily declined until CSA's last year of existence in fiscal year 1981, when appropriations were $526.4 million.

Under a mandate to assure greater self-sufficiency for the elderly poor, CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. CSA programs designed to meet the needs of the elderly poor in local comunities were carried out through a well-defined advocacy strategy which attempted to better integrate services at the State level and at the point of delivery.

## 2. ISSUES

### (A) NEED FOR CSBG

In 1981, the Reagan administration proposed elimination of CSA and the consolidation of its activities with 11 other social services programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The admininstration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and congressional oversight committee had criticized CSA as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus Reconcilation Act of 1981 abolished CSA as a separate agency but replaced it with the community services block grant [CSBG] to be administered by the newly created Office of Community Services under the Department of Health and Human Services.

Although Congress has enabled States to assume responsibility for administering the community services block grant, there has been a reluctance to eliminate the role of CAA's in the actual delivery of service to the community. The CSBG act requires States to submit an application to DHHS, assuring that they will comply with certain requirements, and a plan showing how these assurances will be carried out. States must guarantee that the State legislatures will hold hearings on the use of funds each year. States also must agree to use block grants to promote self-sufficiency for low-income persons, to provide emergency food and nutrition services, to coordinate public and private social services programs and to encourage the use of private sector entities in antipoverty activities. However, neither the plan nor the State application is subject to the approval of the Secretary. States may transfer up to 5 percent of their block grant allotment for use in other programs, such as the Older Americans Act, Headstart, and low-income energy assistance. No more than 5 percent of the funds may be used for administration.

Funding for the new block grant in fiscal year 1982 amounted to a 30-percent reduction from CSA's fiscal year 1981 appropriation. The CSBG received $348 million in fiscal year 1982, plus an additional $18 million for activities related to the phaseout of CSA.

Since States had not played a major role in antipoverty activities when the CSA existed, the Reconciliation Act offered States the option of not administering the new CSBG during fiscal year 1982. Instead, HHS would continue to fund the existing CSA grantees in those States until the States themselves were ready to take over the program. States which did not opt to adminster the block grant in 1982 were required to use at least 90 percent of their allotment to fund existing community action agencies and other prior CSA grantees. In the act, this 90 percent passthrough requirement applied only during fiscal year 1982. However, in appropriations legislation for fiscal year 1983 and 1984, Congress extended the grandfather provision for CAA's and former CSA grantees in order to ensure program continuity and viability. The extension is viewed widely as an acknowledgement of the political stakes inherent to community action agencies and the programs they adminster. Four states, Wyoming, Utah, Nevada, and Colorado qualified for an exemption because a significant portion of their counties were not served by an existing CAA. Congress in 1984 made the 90 percent passthrough requirement permanent and applicable to all States, under Public Law 98-558.

After 2 years of existence, the administration proposed to terminate the CSBG entirely for fiscal year 1984, and to direct States to use other sources of funding for antipoverty programs, particularly SSBG dollars. In justifying this phaseout and suggesting funding through the SSBG, the administration maintained that States would gain greater flexibility because the SSBG provided fewer restrictions. According to the administration, States would then be able to develop the mix of services and activities which were most appropriate to the unique social and economic needs of their residents. Congress, however, has continued to resist the administration's proposal and has continued to support funding for the CSBG, which would be blunted by incorporation into the SSBG.

### (B) ELDERLY SHARE OF SERVICES

The role that the social services block grant plays in providing services to the elderly has been a major concern to policymakers. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for vulnerable groups, including the elderly. In addition, critics have noted that any future reductions in SSBG funding could trigger uncertainty and increased competition between the elderly and other needy groups for scarce social service resources.

The extent of program participation on the part of the elderly under title XX was difficult to determine because programs were not age specific. States had a great deal of flexibility in reporting under the program, and as a result, it was difficult to indentify the number of elderly persons served, as well as the type of services the received. The elimination of many of the reporting requirements under the social services block grant has made efforts to track services to the elderly even more difficult.

It is equally difficult to determine the degree to which SSBG dollars benefits the elderly. Based on the limited data that is available, the Office of Management and Budget estimated in 1981 that some 21 percent of the total title XX dollars went to services for the elderly. More recently, the National Data Base on Aging reported that SSBG funds comprised approximately 6.3 percent of State units on aging budgets and 4 percent of area agencies on aging budgets in 1982.

In addition to problems in determining funding amounts, little data exists on the national level indicating the extent to which SSBG programs are actually coordinated with other programs, or the extent to which services overlap.

The implications of the 1984 General Accounting Office [GAO] study on SSBG services for the elderly are unclear due to the lack of programmatic data on State expenditures. GAO did report that funding for home-based services, which includes trained homemaker services, home maintenance and personal care services, home management services, and home health aid services, fluctuated among the States between 1981 and 1983. Some States reduced funding for these services by simply shifting program support to Medicaid. Florida, for example, choose to target their block grant dollars to disabled adults between the ages of 18 and 59, where previously, the State focused on all elderly and disabled persons. At the other end of the spectrum, Pennsylvania increased their emphasis on home-based services for the elderly as a means of preventing more costly institutionalization.

It seems clear that while funding for the SSBG has remained relatively constant, the potential for fierce competition among competing recipient groups is strongly indicated. Increasing social service needs along with declining support dollars portends a trend of continuing political struggle between the interest of elderly indigent and those of indigent mothers and children. In the coming years, a fiscal squeeze in social service programs could have massive political reverberations for Congress, the administration, and State governments as policymakers contend with issues of access and equity in the allocation of scarce resources. A voluntary survey conducted by the American Public Welfare Association found that in 21 States, people age 60 and older made up 15 percent of SSBG recipients in fiscal year 1983. Comparing 12 of these States with data from the same states in fiscal year 1982, APWA found that the percentage of elderly recipients in these States dropped from 19.1 percent in fiscal year 1982 to 14.7 percent fiscal year 1983. At the same time, the number of children recipients rose from 38.8 percent in fiscal year 1982 to 46.4 percent in fiscal year 1983. The APWA study was released in October 1985.

The proportion of CSBG funds that support services for the elderly and the extent to which these services have fluctuated as a result of the block grant remains unclear. When the CSBG was implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSBG, there is very little information available at the Federal level regarding State use of block grant funds.

A 1984 study by the National Governors Association [NGA] on State use of fiscal year 1983 CSBG funds does provide some interesting clues, however. NGA found that CSBG's 90 percent pass-through requirement to CAA's effectively limited States' discretionary spending. Out of the more than 900 CAA's which had existed in 1981, 861 CAA's were receiving CSBG funds in fiscal year 1983. With respect of funding formulas, States allot funds based on any of the following: The amount received from CSA in fiscal year 1981; a straight formula based on the number of poor people in the communities served by the grantee; a minimum funding level plus an additional amount based on a poverty level. Most importantly, NGA received data on CSBG expenditures broken down by program category and number of persons served which provides some indication of the impact of CSBG services on the elderly (see table 1). For example, expenditures for employment services, which includes job training and referral services for the elderly, accounted for almost 13 percent of total expenditures and served over 400,000 persons. Housing programs, including homeownership counseling, shelters for the homeless, and construction of low-cost housing, served over 765,000 persons in fiscal year 1983, many of whom are elderly. A catchall program category supports a variety of services reaching older persons, including transportation services, medical and dental care, senior center programs, and information and referrals or linkages with other programs. Emergency services such as donations of clothing, food, and shelter, low-income energy assistance programs and weatherization are also provided to the needy elderly through CSBG funds. Combined, these programs reached over 10 million needy persons in 1983. Unfortunately, data related to the age, sex, race, and income levels of program participants was not reported in the NGA survey. Until such data is analyzed, a definitive picture of the role CSBG programs play in assisting the needy elderly is not possible.

TABLE 1.—FISCAL 1983 CSBG EXPENDITURES AND PERSONS SERVED IN 34 STATES BY PROGRAM CATEGORY (SECTION D)

| Program category | CSBG expenditure | Number of persons served |
|---|---|---|
| Employment | $25,189,314 | 433,141 |
| In percent | 12.8 | 1.6 |
| Education | $11,540,553 | 3,456,287 |
| In percent | 5.9 | 12.9 |
| Housing | $15,302,317 | 765,413 |
| In percent | 7.8 | 2.9 |
| Better use of available income | $15,596,558 | 2,069,041 |

TABLE 1.—FISCAL 1983 CSBG EXPENDITURES AND PERSONS SERVED IN 34 STATES BY PROGRAM CATEGORY (SECTION D)—Continued

| Program category | CSBG expenditure | Number of persons served |
|---|---|---|
| In percent | 7.9 | 7.7 |
| Emergency assistance | $20,435,408 | 2,408,978 |
| In percent | 10.4 | 9.0 |
| Nutrition | $28,891,367 | 9,979,727 |
| In percent | 14.7 | 37.3 |
| Linkages with other programs | $80,036,612 | 7,612,167 |
| In percent | 40.6 | 28.5 |
| Total | $196,992,129 | 26,724,753 |
| Total percent | 100 | 100 |

### (C) EFFECT OF BLOCK GRANTS ON FUNDING AND PRIORITIES

The implementation of the SSBG was accompanied by reduced Federal funding. However, in recent years funding levels have been increased slightly. In fiscal year 1982, the national title XX appropriation was $2.4 billion, compared to $2.991 billion in fiscal year 1981—a decrease of 20 percent. Funding for fiscal year 1984 was $2.45 billion from SSBG plus an additional $225 million appropriated through the emergency jobs bill legislation.

The reduction in Federal funding for social services which accompanied implementation of the block grant increased pressure on State and local governments and service providers to maintain program delivery. In response to concern that certain groups, including the elderly, would suffer a reduction in services under the block grant, Congress ordered the General Accounting Office [GAO] to assess the implementation and administration of the new SSBG, and the effect of reduced Federal funding on program priorities. The GAO report was released in August 1984. Although Federal support decreased as States began implementing the SSBG, the GAO found that most States increased their total social services expenditures between 1981 and 1983. This increase was accomplished primarily through increased State and other non-Federal funding as well as transfers from the other Federal block grant programs, such as the low-income home energy assistance block grant. This growth in expenditures, however, rarely kept pace with the increase in inflation during this period. These finding were similar to those of an Urban Institute study, released in 1985, which reviewed block grant spending patterns through 1984.

Generally, service areas funded under title XX continued to receive support in 1983 under the SSBG as States attempted to maintain program continuity. However, the reduced SSBG allocations caused States to reorder the priorities of individual service areas, reduce or eliminate services, and alter client eligibility criteria. GAO reported that States gave higher priority to adult and child protective services, adoption and foster care, home-based services, and family planning. The Urban Institute also found States have tended to shift their priorities toward crisis intervention services, protective services. The GAO report also offered insight for better understanding the political debate over the block grant approach. The majority of State officials view the block grants program as more flexible and less burdensome than prior programs. The majority of interest group representatives, however, believe that the block grant has resulted in a decrease in funding for social services and has had a generally negative impact on the interests of the groups they represent. While interest groups and State officials had differing views on the desirability of the block grant, both expressed concern about the Federal funding reductions that accompanied the block grant. Notably, many States believe that the advantages of the SSBG are diminished by reduced Federal funding, and that additional program discretion may be hampered by fiscal constraints imposed by the Federal Government.

Questions also remain regarding the effect of the CSBG program on the range and quality of services delivered in the community. When Congress shifted the primary administrative responsibility of numerous CSA categorical programs to the States under the CSBG, States' discretionary authority dramatically expanded over their prior limited involvement in community action program activities. Under both the OEO and CSA, almost all community service grants were made directly to local providers. States' roles were essentially to provide liaison activities and other support functions, usually through grants to State economic opportunity offices. Few States had State-supported community services programs. Consequently, most States had no existing framework for planning community services. Given the States' limited experience in this area, and the reduction in Federal funding which accompanied the block grant, critics of the CSBG approach predicted adverse effects on program implementation and service delivery.

During 1982 and 1983, the General Accounting Office surveyed several States to assess the implementation and administration of the new CSBG, and the effect of reduced Federal funding on program delivery. The GAO report was released in September 1984. The substantial decline in Federal funding, which was not offset by the infusion of State funds, created numerous changes in CAA support, the GAO found. The majority of CAA's sustained substantial funding reduction. Many providers have taken steps to compensate for reduced funds, such as charging fees, soliciting private contributions, seeking other Federal funding sources, and increasing the use of volunteers. The majority of providers, however, have reduced or eliminated services. Similar findings were reported by the Urban Institute in 1985, which found that States generally had not attempted to replace lost Federal dollars with their own funds.

Several conclusions can be drawn from the GAO study. In general, States have not taken advantage of the expanded authority under the CSBG to make substantial programmatic changes. Instead, States have carried out their block grant management responsibilities by establishing program requirements, monitoring service providers, providing technical assistance, collecting data, and arranging for audits. However, the States' level of involvement in setting program priorities may increase as State administrative units acquire additional experience and knowledge of community service needs. The escalating demand for scarce community service dollars and the corresponding political pressure from interest groups, in turn, may threaten to splinter community action programs into disjointed and ineffective parts. Consequently, this shift in program discretion from the CAA's to centralized State units will require more thoughtful public discourse on the assignment of service priorities in order to ensure an equitable distribution of services under the block grant.

The Urban Institute found that, to the extent possible within the constraints of the 90 percent passthrough requirement, States have shifted funds away from large urban community action agencies and have attempted to fund new agencies not previously financed under the Community Services Administration.

## 3. LEGISLATION

### (A) SSBG APPROPRIATIONS

The 1981 Budget Reconciliation Act fixed authorization levels at 20 percent below fiscal year 1981 levels with slight increases for inflation. Authorization levels were set at $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year 1984, $2.6 billion in fiscal year 1985, and $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized. States are entitled to receive a share of the total according to their population size.

In the fiscal year 1984 budget request, the administration originally requested the fully authorized amount of $2.5 billion. However, the administration subsequently lowered its fiscal year 1984 request for the SSBG to $2.44 billion. At the same time, the White House proposed to terminate all funding for two related programs, the community services block grant and the work incentive program, and allow States to continue these activities using SSBG funds. No corresponding funding increase in the SSBG was proposed, however.

For fiscal year 1986, President Reagan requested that the full entitlement level of $2.7 billion be appropriated for the SSBG. In its nonbinding first concurrent resolution on the fiscal year 1986 budget, the Senate Budget Committee endorsed the President's request. This resolution (S. Con. Res. 32) was passed on May 10, 1985. The House version of the resolution, passed on May 23, also assumed $2.7 billion for the SSBG. The final conference version of the resolution, assuming $2.7 billion for the SSBG, was passed by both the House and Senate on August 1, 1985.

On September 26, the House Appropriations Committee reported H.R. 3424, a fiscal year 1986 appropriations bill for the Departments of Labor, HHS, and Education (H. Rept. 99-289). This measure contained $2.7 billion for the SSBG and was passed by the full House on October 2. The Senate Appropriations Committee approved its version of H.R. 3424 on October 4 (S. Rept. 99-151). The Senate version also contained $2.7 billion for the SSBG and was passed by the full Senate on October 22. The House and Senate agreed to the conference report on H.R. 3424 (Conf. Rept. 99-402) on December 5 and 6 respectively.

The final version of the Labor, HHS, and Education appropriations bill was signed by the President on December 12, 1985 (Public Law 99-178) and included $2.7 billion for the SSBG.

### (B) CSBG APPROPRIATIONS

As established in the 1981 Omnibus Budget Reconciliation Act, the CSBG was scheduled to expire at the end of fiscal year 1986. Legislation to reauthorize CSBG as well as the Head Start program and the Low-Income Energy Assistance Program through 1987 (S. 2565), was approved by the Senate Labor and Human Resources Committee on May 9, 1984.

An amended version of S. 2565, which did not extend CSBG beyond its 1986 expiration date but increased authorization levels for spending in fiscal year 1985 and 1986, passed the Senate by a voice vote on October 4 and was passed by the House on October 9. President Reagan signed the measure on November 1, 1984 (Public Law 98-558). This final version of the legislation also extended or amended Head Start, Follow Through, several higher education programs, Low-Income Home Weatherization, Low-Income Energy Assistance, and Native American Programs. Under the new law, CSBG spending levels are increased to $400 million in fiscal year 1985 and $415 million in fiscal year 1986. The requirement that States passthrough at least 90 percent of their allotment to former CSA grantees and other eligible entities is made permanent by this legislation. However, up to 7 percent of the passthrough funds may be granted to an agency that has not been considered an eligible entity the previous year. This provision gives added flexibility to States who would prefer greater discretion on the use of their CSBG allotment, and reflects a compromise agreement reached between members of the Senate Labor and Human Resources Committee. Also, provisions were established for expanding services under CSA, and for reviewing decisions of funding denials to grantees. States may increase eligibility criteria to 125 percent of the poverty line under the new law. Finally, the legislation authorized $2.5 million for both fiscal years 1985 and 1986 for a Community Food and Nutrition Program. The purpose of CFNP is to support local community efforts to improve the delivery of direct nutritional assistance to low-income persons.

As in the last several fiscal years, President Reagan proposed to terminate the CSBG in fiscal year 1986 and requested only $3.9 million in fiscal year 1986 for Federal administrative costs related to closing down the program. In addition, the administration proposed to rescind $34,000 of the fiscal year 1985 appropriation in response to section 2901 of the Deficit Reduction Act, which directs Federal agencies to reduce spending for such activities as travel and consulting services. This rescission was not approved.

In its nonbinding first concurrent resolution on the fiscal year 1986 budget (S. Con. Res. 32) the Senate Budget Committee endorsed President Reagan's request to terminate the CSBG. However, when the committee's version of the resolution reached the Senate floor, it was replaced with a compromise package which would continue the CSBG in fiscal year 1986, at a 36-percent reduction, and terminate the program completely in fiscal year 1987.

The House version of the resolution, however, would maintain the CSBG at its fiscal year 1985 appropriations level, plus an adjustment for inflation. The House version prevailed in conference committee and the conference report was passed by the House and Senate on August 1.

The House appropriations bill for the Departments of Labor, HHS, and Education (H.R. 3424), contained $361.7 million for the CSBG and related activities. This total consists of $326.7 million for block grants to States, $33.1 million for discretionary activities, and $4.3 million for Federal administrative costs associated with 55 full-time staff at OCS. The Senate committee also rejected the administration's request to use CSBG funds for the Federal task force on the homeless. The final version of the appropriations bill (Public Law 98-178) included $335 million for block grants to States, $31 million for discretionary activities, and $4.3 million for Federal administrative costs.

## B. HOMELESS SERVICES

### 1. BACKGROUND

In the past few years, the problem of homelessness has grown enormously. The absolute numbers of homeless people have increased dramatically, and their tragic plight has attracted a great deal of concern and publicity among the media, Congress, State and local government, and the public at large. For the most part, public attention has focused on finding basic food and shelter for the homeless. Old buildings have been converted into shelters, soup lines have been established, and substantial public and private resources have been mobilized to meet the most immediate needs of the homeless.

Efforts to combat homelessness have been initiated at all levels of government, and in the private and nonprofit sectors. Most of the resources that have been mobilized have been directed toward providing short-term emergency food and shelter. The Department of Housing and Urban Development (HUD) estimates that over two-thirds of all funding for shelters comes from private sources. The great majority of shelters nationwide are run by nonprofit organizations, many with religious affiliation.

In terms of public sector involvement, each level of government has contributed to providing emergency shelter to the homeless. The most direct of public sector assistance to the homeless is through local governments. The vast majority of cities and counties are involved in operating shelters, providing funds or buildings to privately operated shelters, and paying for homeless people to stay in private hotels and apartments. Most of these activities are funded through Federal and State funds, but some localities do use local revenues to aid the homeless.

At the Federal level, Congress has appropriated $210 million for the homeless. These funds have been distributed through a national board of charitable groups, such as the Salvation Army and Catholic charities, with the Federal Emergency Management Agency [FEMA] monitoring the effort. According to the program regulations the funds may be used for—food and associated supplies; the costs of keeping a shelter open and rehabilitating a shelter; hotel/motel vouchers; and, for one time only, limited energy and rent or mortgage assistance to individuals and families to prevent eviction. Federal funds distributed through the Community Services Block Grants and the Social Service Block Grants can be used for the homeless, contingent upon the discretion of State and local governments. Also, the Alcohol, Drug Abuse, and Mental Health Service Block Grants can be used by States and localities to fund mental health services for the homeless. In addition, the Federal Government provides special assistance through the Temporary Emergency Food Assistance Program [TEFAP], which provides moneys to States and localities for costs associated with the provision of commodities to soup kitchens and other organizations.

The role of State governments in providing for the homeless has primarily been in the area of channelling the Federal block grant and FEMA funds to local governments. Unfortunately, data on the extent to which these block moneys go to the homeless are not available. Direct State funding or operation of shelters is rare. States do, however, play a critical role in determining the funding of mental health institutions and services.

## 2. Issues

### (A) NEED

Over the past few years, the plight of the Nation's homeless and hungry has attracted a great deal of concern and publicity. Although reliable statistics are hard to find, it is clear that an enormous number of Americans are homeless—probably between 250,000 and 3 million. The Department of Housing and Urban Development unleashed a storm of controversy with a May 1984 report that concluded that there were only 250,000 to 350,000 homeless persons nationwide. Other groups that help the homeless insist that the total is about 10 times that amount.

While no one knows precisely how many Americans are going hungry or are malnourished, institutions involved in providing emergency food assistance have seen dramatic increases in the numbers of people seeking food assistance during the past few years. According to a report released in January 1986 by the U.S. Conference of Mayors, hunger and homelessness rose sharply (28 percent and 25 percent, respectively) in the 25 urban areas surveyed in 1985.

In April 1985, the General Accounting Office released a report on homelessness showing that there was widespread agreement that homelessness is increasing. GAO found that while a reduction in the unemployment rate may help to reduce the number of homeless, deinstitutionalization of mentally ill persons, and a continuing decline in low-income housing and public assistance programs may be offsetting any effect on the overall number of homeless persons. Many also believe that the official unemployment rate does not accurately reflect the actual unemployment problem because it fails to take into account the underemployed and discouraged workers (those who have given up searching for jobs).

Homelessness stems from a variety of factors—unemployment, social service and disability cutbacks, lack of aftercare services for the deinstitutionalized mentally ill, and housing shortfalls in urban areas. The deinstitutionalized chronically mentally ill comprise the most substantial portion of the homeless—about one-third of the total. According to the administration's Interagency Task Force on Food and Shelter for the Homeless, the number of patients in mental hospitals decreased from 505,000 in 1963 to 125,000 in 1981. The fastest growing group among the homeless, however, is unemployed individuals and their families. The 1986 U.S. Conference of Mayor's report states that 60 percent of the homeless are single men, 12 percent are single women, and 27 percent are families with children. The cities reported an 85 percent increase in homeless children, reflecting a trend that began with the recession. Recent studies have also documented a new dimension—the suburban homeless. According to reports, in some relatively affluent suburban communities with rising housing costs, families who earn the minimum wage, or barely above it, cannot afford apartments or houses, and instead, are living on the streets, in publicly funded shelters, or in their automobiles.

For the elderly homeless, a great deal of the problem results from the lack of health care and affordable housing due to skyrocketing rents, elimination of single-room-occupancy hotels, and a shrinking supply of low-income housing. The Reagan administration, for example, has stopped new construction of low-income housing, while cutting annual Federal subsidies from $30 billion to $10 billion since fiscal year 1981. In the meantime, the number of people on waiting lists for low-income public housing has burgeoned.

For the mentally disabled, the policy of deinstitutionalization has led to the employing of State hospitals, but with no intermediate community services other than community mental health centers. Many believe that these centers are underfunded, uncoordinated, and do not address the shelter needs of the chronically mentally ill in a significant way. Unfortunately, the homeless must negotiate their way through a fragmented, complicated, and often hostile system of income, housing, health and social service agencies and programs.

### (B) ADEQUACY OF SERVICES

Private and public resources have been mobilized to attempt to meet the immediate needs for food and shelter. The Emergency Food and Shelter program, currently administered by the Federal Emergency Management Agency (FEMA), has provided over $200 million for food, shelter, and other forms of assistance to the homeless. The program was initiated in the Emergency Jobs Appropriations Act approved in March 1983 (Public Law 98-8), and has continued through appropriations in subsequent years. Originally, funds for the program were disbursed through two channels. One was through a national board composed of representatives from six charitable organizations and from FEMA itself. The other was through the States to whom FEMA was authorized to distribute

$50 million for further allocation to local distributors and service agencies. The State channel was subsequently eliminated.

Delays in the State channel seem to have caused its elimination. In an evaluation of the shelter program, in 1985, the Urban Institute noted the speed and flexibility with which the national board and the nonprofit sector were able to get money for emergency food and shelter to the local communities. According to the Urban Institute, delays in the State channel resulted from lack of State authorizing legislation, State requirements for written regulations, State requirements for proposal and assessment processes, obligations without distribution, and time lags because of State coordination requirements.

By most accounts, the FEMA program, which has utilized local programs rather than duplicating their efforts by applying a new layer of bureaucracy, has worked well. In 1984, $110 million was provided by the Federal Government for this program. From that amount, about 1 million meals were served, and approximately 15 million nights of shelter was provided. On average, a meal provided from these funds cost less than 75 cents; a night in a shelter cost less than $3.

Hundreds of citizens have also voluntarily donated time and money to help feed the hungry and house the homeless. But even with these efforts, optimistic statistics show that only one in three homeless individuals would have a bed and a bowl of soup in a public or private shelter during the winter of 1985. Other figures suggest that only 1 out of every 20 will be so fortunate. Both figures illustrate how much is yet to be done. Most recently, the U.S. Conference of Mayors reported that, in half of the 25 cities they surveyed, homeless people are routinely turned away from overcrowded shelters and 17 percent of the demand for emergency food goes unmet.

## 3. Legislation

### (A) FISCAL YEAR 1986 ADMINISTRATION BUDGET

The Reagan administration contends that homelessness is a local problem and maintains that the Federal role should be limited to making available to the homeless, surplus resources such as food and buildings. In his 1986 budget request, President Reagan proposed continuing the Interagency Task Force on Food and Shelter for the Homeless, which coordinates administration efforts to aid the homeless. At the same time, however, the administration wanted to eliminate the program of the Federal Emergency Management Agency [FEMA] that has provided emergency funding for food and shelter for the homeless over the past 3 years. The President also called for cutting block grants for community services and development that have been used by some States and localities to provide food and shelter to homeless individuals. In addition, the administration wanted to eliminate TEFAP, the emergency feeding program within the Department of Agriculture.

The administration's task force was created in October 1983 and was charged with coordinating Federal efforts to help the homeless by identifying potential resources controlled by Federal agencies and by cutting bureaucratic red tape to make the resources available to the homeless. By late 1984, the task force had reportedly reached agreements with the General Services Administration and the Departments of Defense, Housing and Urban Development, Transportation, and Agriculture to lease surplus facilities to be used as homeless shelters, or to make food donations to the shelters. According to the Congressional Quarterly, however, no figures were available on the anticipated numbers of beds or the amounts of food and other aid likely to be provided. Critics of the task force charge that little surplus food and shelter have materialized and argue that Federal agencies have been uncooperative in providing aid to the homeless. The efforts of the task force were sharply criticized by the House Government Operations Subcommittee on Intergovernmental Relations and Human Resources.

### (B) HUD APPROPRIATIONS

The primary response of the Federal Government to the problem of homelessness in the Nation has been through the Emergency Food and Shelter Program administered by FEMA. In June 1985, the Senate passed an amendment to the second supplemental appropriations bill (H.R. 2577), sponsored by Senator Dixon and Senator Heinz, appropriating $110 million for the homeless through 1986. Subsequently, the conference committee recommended that $20 million be appropriated for the remainder of 1985 and that any funds for 1986 be included in the 1986 HUD-Independent Agencies appropriations bill. The House then included $70 million for fiscal year 1986 for the homeless, but the Senate Appropriations Committee cut this back to $50 million in mark-up.

On October 17, 1985, Senators Dixon and Heinz, successfully introduced an amendment to H.R. 3038, the HUD-Independent Agencies appropriations bill, adding $20 million to the Senate version of the bill, to bring it in line with the House-passed version, which contained $70 million for the homeless for fiscal year 1986. On the same day, the Senate unanimously accepted a second degree amendment to the Dixon-Heinz amendment, which would have established a permanent homeless program, by trnsferring the FEMA program to the Department of Housing and Urban Development (HUD) and authorizing the program for 3 years. While the $70 million apppropriation for the homeless was accepted in conference, the homeless housing assistance amendment was deleted. Senator Garn reported that the House conferees were intransigent in their demand that the amendment be stricken because they felt that the amendment needed further discussion and study.

### (C) OTHER LEGISLATION

On March 26, 1985, Senator Heinz, Senator Dixon, and Senator Glenn introduced S. 739, the "National Endowment for the Homeless Act," which would establish a private, nonprofit organization to help meet the long-term needs of the homeless. Under the proposal, the Federal Government would provide a minimum of $110 million in each of fiscal years 1986 through 1988, and up to $50 million a year to match local contributions on a one-to-one basis. The endowment would offer grants to community organizations which serve the homeless. In addition to funding survival-oriented services, the endowment would also make special grants for creative, new approaches by private groups addressing the long-term, fundamental needs of the homeless. It would improve linkages between private and public strategies and would function as a national clearinghouse for information.

Similarly, on July 23, 1985, Senators Gorton and Moynihan introduced S. 394, the "Homeless Assistance Act of 1985." The bill would establish three separate programs: (1) continuation of the emergency food and shelter program currently administered by FEMA, with a transition to administration under HUD; (2) a program providing competitive advances to States, local government, and nonprofit organizations for renovation or conversion of buildings to use as emergency shelters, with repayment being waived if the building is used for 10 years as a shelter; and (3) a demonstration project of transitional small-group housing to assist homeless individuals in the transition to independent life.

H.R. 1, introduced on January 3, 1985, and sponsored by Representative Henry B. Gonzalez, chairman of the House Banking Subcommittee on Housing, is a wide-ranging bill authorizing most housing programs through fiscal 1986 and includes an authorization for $200 million for FEMA to continue homeless aid. The bill would also establish a pilot program to address in a more permanent manner the needs of the homeless. It would authorize up to $100 million in loans to build, repair, or renovate housing for up to 12 people and to pay the salary of a counselor.

Many homeless qualify for public assistance, but are either unaware of the programs or unable to apply because they have no address. Some, for example, qualify for Supplemental Security Income (SSI), which provides aid to the needy blind, disabled, and elderly. Others qualify for other benefits, such as food stamps and veteran's benefits. Some Members of Congress have introduced measures to direct existing social services to the homeless. For example, a bill introduced by Representative Stewart McKinney (H.R. 1479) would require States to have a comprehensive mental health plan, including sufficient community facilities for the deinstitutionalized mentally ill, and would tie that responsibility to eligibility for Federal block grants. Several legislative proposals, such as a bill introduced by Representative Ted Weiss (H.R. 1526) would provide extra services to improve efforts to move the homeless toward self-sufficiency. The act would authorize the Secretary of Health and Human Services to provide grants, on a competitive and matching basis, to local governments or nonprofit corporations for the provision of emergency services to homeless individuals. It would also fund demonstration programs to develop so-called "second-stage" housing, which provides supervised quarters, counseling, and other services, such as job training.

In addition to existing State block grants that allow funds to be spent for the homeless, the Federal Government provided special assistance through the Temporary Emergency Food Assistance Program [TEFAP], which provides funds for costs associated with the provision of commodities to low-income persons through soup kitchens and other organizations.

Unfortunately, House and Senate efforts to include homeless provisions from H.R. 1 and the Gorton proposal, as a part of the budget reconciliation measure, S. 1730, also failed and no homeless provisions were adopted in the final conference report on that measure. During the final hours of the first session of the 99th Congress, the House and Senate were unable to reach agreement on Superfund provisions and adjourned sine die without passing the reconciliation bill.

### 4. PROGNOSIS

Most Members of Congress believe that solutions to the problem of homelessness should be developed at the local level. Unlike the administration, however, they feel that the Federal Government has an important role to play in the solution. In 1985, Congress chose to continue to fund the FEMA program on an ad hoc basis, as it has done in the past. Thus, while Congress has reduced the risk of men and women dying in the streets due to malnutrition and exposure, it has so far failed to provide lasting solutions for the range of problems facing the homeless—especially their mental and physical health needs.

It is clear, however, that long-term solutions to the problems of homelessness are needed. The debate is now focused on a determination as to which approach is the most reasonable. In general, the current legislative proposals have one or more of three aims: Providing cash assistance to which homeless people may be entitled, but which they are not receiving; subsidizing emergency food and shelter providers; and assisting the homeless to move into more permanent living arrangements. Budgetary realities significantly dampen the chances of an expensive program to aid the homeless—but since most of the proposals are relatively modest and many continue existing programs or provide the same amount as was spent in fiscal year 1985, they can be expected to be continued in the future or modified only slightly.

## C. EDUCATION

### 1. BACKGROUND

State and local governments have long had primary responsibility for the development, implementation, and administration of primary, secondary, higher education, and continuing education programs benefitting students of all ages. The role of the Federal Government in education has been to ensure equal educational opportunity, to enhance the quality of education, and to address national priorities in training.

Federal and State interest in developing education opportunities for older persons grew out of a paper prepared for the 1971 White House Conference on Aging which cited a hierarchy of educational needs for older persons. These range from the need to acquire the basic skills necessary to function in society, to the need to engage in activities throughout one's life which are enjoyable and meaningful and which benefit other people. The 1981 White House Conference on Aging report entitled, "Implications for Educational Systems," noted that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older persons, and assure a match between the needs of older adults and the training of those who prepare to serve them.

While many strong arguments exist for the importance of formal and informal education opportunities for older persons, in reality, it has traditionally been a low priority in education policymaking. Public and private resources for the support of education have been directed primarily to the establishment and maintenance of programs for children and youth, including those of the traditional college ages. This is due largely to the perception of education as a foundation constructed in the early stages of human development—a kind of intellectual investment drawn upon for discrete withdrawals throughout one's adult life.

While formal education is viewed as a finite activity extending only through early adulthood, learning continues throughout one's life in experiences with work, family, and friends. Thus, it is a relatively new notion that a need exists for learning beyond the informal environment for the elderly. This need for structured learning may appear among "returning students" who have not completed their formal education, older workers who require retraining in skills adaptable to rapid technological change, or retirees who desire to expand their knowledge and personal development. A growing awareness of the importance of education for the elderly has resulted in some reordering of priorities and resource allocation away from the basic education/literacy and training programs established for older adults in the early 1960's. While Federal programs have generally lagged, recently private and public-based education programs have emerged which are designed to better meet the growing educational needs of older persons.

## 2. Issues

### (A) ADULT LITERACY

Literacy means more than just the ability to read and write. Literacy is more clearly defined as the essential knowledge and skills necessary for effective functioning in the home, community, and workplace. According to some estimates, as many as 27 million Americans, or one in five adults, function with great difficulty in our society. An additional 47 million can function but not proficiently. These figures mean an astonishing 74 million Americans function in society at a marginal level or below. When the inherent problems associated with illiteracy are considered—unemployment, crime, homelessness, alcohol and drug abuse—the cost of widespread illiteracy in this country is staggering.

Of all adults, the group 60 years of age and older has the highest percentage of people who are functionally illiterate. Results of one study showed that 35 percent of adults 60 to 65 years of age lack the skills and knowledge necessary to cope successfully in today's society. These figures reflect the direct correlation between educational attainment and literacy. As would be expected, there is a heavy concentration of older persons among the groups of adults 16 years and over with less than a high school education. Of those with less than a high school education, more than three-quarters of those 65 and over have not completed grade school. In the early 1970's, under a Federal education grant, the Adult Performance Level (APL) study was undertaken at the University of Texas. The objective of the study was to develop a more complex set of reading and writing competencies that were related to adult economic and educational success in contemporary American society (Northcutt, 1975). The study developed a set of five general knowledge areas and four sets of primary skills. The knowledge areas were—consumer economics, occupational knowledge, community resources, health, and government and the law. The primary skills were—communication (reading, writing, speaking, and listening), computation, problem solving, and interpersonal relations.

The APL project established three levels of functional competencies: APL 1, APL 2, and APL 3. Adults in the APL 1 category are functionally incompetent (or function with difficulty) and have skills that are associated with (but do not determine) inadequate income at the poverty level or lower, inadequate education equivalent to 8 years of school or less, and are unemployed or have occupations of low job status. Adults in the APL 2 category are marginally functional (or competent, or "just get by") and have skills associated with income above the poverty level (but no discretionary income), education of 9 to 11 years of school, and occupations with median job status. Adults in the APL 3 category are functionally proficient and have mastered the skills associated with high levels of income, completion of at least 12 years of school, and high job status.

The APL study (represented in table 2) and a Census Bureau illiteracy tabulations in table 3 reveal the acute problem older Americans face as the most illiterate segment of our society.

TABLE 2.—ADULT PERFORMANCE LEVEL [APL] PERCENTAGES, 1975

[In percent]

| Category | APL competency level | | |
|---|---|---|---|
| | Incompetent | Marginal | Proficient |
| Overall competency | 20 | 34 | 46 |
| Ages: | | | |
| 18 to 29 | 6 | 35 | 49 |
| 30 to 39 | 11 | 29 | 60 |
| 40 to 49 | 19 | 32 | 49 |
| 50 to 59 | 28 | 37 | 35 |
| 60 to 65 | 35 | 41 | 24 |

Source: Northcutt, 1975.

TABLE 3.—PERCENTAGE OF THE AMERICAN POPULATION ILLITERATE, 1979

| Age | Total | White | Black |
|---|---|---|---|
| All persons 14 years and over | 0.6 | 0.4 | 1.6 |
| Persons 14 years to 24 years | .2 | .2 | .2 |
| Persons 25 years to 44 years | .3 | .3 | .5 |
| Persons 45 years to 64 years | .8 | .6 | 2.6 |
| Persons 65 years and over | 1.7 | 1.1 | 6.8 |

Source: U.S. Bureau of the Census, 1982, Table 8 (footnotes omitted).

Generally, the higher educational system in the United States has failed to address the needs of the older, illiterate adults. Although adult education programs exist throughout the country, less than 2 million participate in the programs, and most have a higher education level than the median for older adults. It has been suggested that Federal education programs designed to meet specific, categorical objectives have been responsible, in part, for the failure to prevent adult illiteracy. Advocates of the block grant approach toward social services funding, including the Reagan administration, have suggested that this approach would reduce administrative costs and increase overall coverage and flexibility in literacy initiatives. However, specific targeting requirements and regulations would need to be an integral part of any program consolidation because recent evidence indicates that adult education funds would be otherwise used to serve persons who require less extensive literacy training. In other words, the reduced payments which often accompany block grant funding could prove to be an incentive for States to allocate their scarce dollars to those persons who require less resources to train—those with better jobs, more education, and higher incomes. The ambiguity surrounding the block grant approach makes any comprehensive reordering of literacy priorities problematic.

In response to the President's Commission on Excellence in Education report concerning the quality of education in America, the Reagan administration made the elimination of illiteracy a major focus. The Adult Literacy Initiative was launched in the Department of Education on September 7, 1983. According to a statement by former Secretary of Education Bell, the Initiative is designed "to increase national attention to the promotion of adult literacy and to enhance existing literacy programs, while utilizing the Department's expertise in coordinating literacy programs nationwide" (Bell, 1983). The Initiative is not a legislatively mandated program, but is based on various discretionary authorities available to the Secretary of Education.

The Initiative's current operations include: (1) Cooperating with the Coalition for Literacy and the Advertising Council in sponsoring a National Awareness Campaign on adult literacy, including an "800" number Literacy Hotline; (2) redirecting part of the College Work-Study program to employ students in literacy programs; (3) encouraging student and adult volunteers as literacy tutors; (4) working with the Federal Employee Literacy Training (FELT) program, whereby all Federal agencies are encouraging employees to volunteer as literacy tutors; (5) sponsoring national meetings and conferences; and (6) developing private/public sector partnerships, including support for the Business Council for Effective Literacy (Bell, 1983; U.S. Dept. of Education, 1985a and 1985b).

### (B) ADULT EDUCATION

The Department of Education is authorized under the Adult Education Act (Public Law 98–750) to provide funds for educational programs and support services benefitting all segments of the eligible adult population. The purpose of the act is to establish adult education programs that will enable adults 16 years and older to:

(1) Acquire basic skills needed to function in society, and (2) assist them in continuing their education until completion of the secondary level, if desired. Funds provided for adult education support State formula matching grants to combat functional illiteracy for adults over 16, and are distributed by a formula based on the number of adults in a State without high school diplomas who are not currently enrolled in school.

In 1977, a major change began in adult education enrollment. The enrollment of those aged 16 to 44 decreased while the enrollment of these age 45 to 65 increased. A 1981 survey entitled "Participation in Adult Education" conducted by the National Center for Education Statistics (NCES) revealed that 768,000 persons age 65 and older, or 3.1 percent of all older Americans, participated in educational activities. Although the majority of adult education participants are under 35, this marked the highest number of proportion of older people involved in adult education ever recorded by NCES. Even more dramatic—the number of persons 65 and older participating in adult education has almost tripled, growing at the average rate of 30 percent for every 3 years compared to an average rate of 12 percent for adult participation of all ages.

Nevertheless, with less than 5 percent of the elderly population enrolled in an educational institute in 1981, older people continue to be underrepresented in education programs in relation to their proportion of the total U.S. adult population. This is due partly to the fact while older persons certainly have the ability to learn, the desire to learn is a function of educational experience. For example, the NCES reported in 1981 that the level of participation in adult education rose at each higher educational level from 2.2 percent of the total population with less than an 8th grade education to 31 percent with 5 years of college or more. Further, a 1981 NCCOA/Harris survey supports this correlation between years of schooling completed and participation in adult education.

The existence of special classes and programs geared to older adults within structured adult education programs is still relatively rare except in community senior centers. Most of the classes focus on self-enrichment and life-coping skills and are gradually shifting to education programs on self-sufficiency. Few programs currently exist to meet the growing demand for the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift their emphasis from personal interest courses to include job-training skills.

For 3 years prior to this year, the Reagan administration had proposed consolidating Federal aid to vocational education and adult education programs into a simplified block grant to States. Concern was raised, however, that this proposal ignores fundamental differences between vocational education—which serves those adults who require retraining for employment, and adult education—which acts as a basis for learning in later life, and would only weaken these successful programs. As a result, Congress consistently rejected this proposal to simplify the program and increase States' discretion, and it was not recommended by the administration this year.

### (C) HIGHER EDUCATION

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfaction of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. A recent study found that younger students studying together with persons their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and they were able to identify them as peers. This finding rebukes the myth that older students somehow take away learning opportunities from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom.

In response to this challenge, some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college after several years. At Smith College, for example, the Ada Comstock Scholar Program offers a traditional education to women older than undergraduates of traditional age. Older students are fully integrated into the academic and campus life, although Ada Comstock students are allowed to take as long as they need or want to complete their college requirements. The older students, in return, bring an added dimension and vitality to the classroom by sharing their broad-based life experiences and interest in learning.

For those older students who cannot afford the cost of a private college, some States are moving to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer full tuition waiver and allow participants to take regular courses for credit in State-supported institutions. Since only two States provide reimbursement to individual institutions which waive tuition payments, the participating colleges must make substantial investments in terms of curricular emphasis and financial support toward meeting the needs of older students.

### (D) ELDERHOSTEL

Elderhostel was inspired by the youth hostels and folk schools of Europe, and is based on the conviction that retirement and later life represents an opportunity to enjoy new experiences. Elderhostels are short-term residential, campus-based educational programs provided to older persons at modest cost. Courses offered are in the liberal arts and sciences and presuppose no particular level of formal education on the part of the student. Most elderhostel programs deliberately avoid age-specific focus on the problems of aging.

Since the inception of elderhostel in New Hampshire in 1975, dramatically increasing numbers of older adults have enrolled in the programs. In 1984, over 700 private and public colleges and educational institutions in 50 States and Canada served 80,000 summer and academic year hostelers. In addition, over 5,000 hostelers participated in programs in Scandinavia, France, Germany, the Netherlands, Italy, and Great Britain. Even with the burgeoning numbers of participants, however, elderhostel remains essentially an educational opportunity reserved for mobile older adults with a relatively high education attainment level.

### (E) INTERGENERATIONAL PROGRAMS

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly age-segregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward providing the support, teaching, and caring that would enhance the learning and development of schoolchildren. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. Today, there are more than 100 intergenerational school programs nationwide. Over 250,000 volunteers participate in grades kindergarten through 12th.

Intergenerational school programs range from informal and haphazard to large, centrally organized programs reaching over several school districts. One such model program is the Senior Citizen School Volunteer Program [SCSVP] established at the University of Pittsburgh as part of the Generations Together consortium of intergenerational programs. SCSVP is a nonprofit independent program that contracts with individual school systems which have demonstrated an interest in developing or maintaining a school volunteer program. In 1983-84, SCSVP placed some 345 volunteers over age 55 in over 60 schools in western Pennsylvania.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons' self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children, and to better cope with their own personal trauma, such as the death of a spouse or friend. These programs also allow schoolchildren to develop a more positive view of older persons and aging while benefitting from the social and academic experience of their older tutors.

The Federal role in promoting intergenerational school programs has expanded recently through a joint initiative sponsored by the Administration on Aging and the Administration for Children, Youth, and Families in the Department of Health and Human Services. This Federal effort consists of four major components: (1) Establishing an information bank of intergenerational programs across the country; (2) disseminating this information to organziations interested in establishing such programs; (3) working with professional organizations to stimulate interest; and (4) funding intergenerational demonstration projects.

## 3. LEGISLATION

There have been no significant activities directly related to the education of older persons to date during the 99th Congress. A possible exception is the bill reauthorizing the Higher Education Act, H.R. 3700, which was reported by the House Committee on Education and Labor on November 20, 1985; title I of that bill would authorize post-secondary education programs for nontraditional students, including adult students beyond the traditional college age group. The current title I authorizes similar programs, but has not been funded since it was previously amended in 1980.

Four major education bills were, however, enacted in 1984, which in part, are designed to provide educational assistance to older persons: Adult Educational Act, Vocational Education Act, Library Services and Construction Act, and the Labor-HHS-Education appropriation bill. In supporting this education package, Congress sent a strong message of their commitment to allocate greater resources to improve the access and quality of the Nation's educational systems.

On June 29, 1984, the Senate passed S. 2496, the Adult Education Act amendments of 1984, as reported by the Senate Labor and Human Resources Committee [S. Rept. 98-503]. This act was later incorporated into an omnibus education reauthorization measure, H.R. 11, and approved by a House-Senate conference committee on October 1. The legislative package, renamed the education amendments of 1984, was signed by President Reagan on October 19 [Public Law 98-511].

Under the new law, Federal spending authorization for adult education is increased by 40 percent, from $100 million to $140 million in fiscal year 1985 and such sums as may be necessary for the three succeeding fiscal years. The amendments make a number of technical changes to the Adult Education Act, but continue the primary purpose of the AEA to assist States in providing literacy skills to educationally disadvantaged adults. Under previous law, section 309 of the AEA required the Secretary of Education to support various research projects, including activities which improve adult education opportunities for elderly persons; however, this section had never been funded. The new law requires that 5 percent of appropriations be set aside for activities authorized under this section, if AEA appropriations total $112 million or more.

Federal library funds are used to assist States in upgrading and extending library services. Libraries are viewed as an integral part of the national education system and commitment to lifelong learning. The Federal contribution to these programs, while relatively small, is critical to the ability of libraries to serve the total population, in particular the homebound, economically needy, and illiterate. Since the enactment of the LSCA in 1956, access to public library services had grown from 56 percent of the U.S. population to 96 percent in 1984.

The Library Services and Construction Act of 1984 [LSCA] extends authorization for such programs as library services, public library construction, and interlibrary cooperation through fiscal year 1989 and extends funding for library literacy programs through 1988. The authorized spending level for all six titles of the LSCA is set at $161 million in fiscal year 1986, with small increases authorized in succeeding years. In addition to declaring in the purpose of the act the goal of improving State and local public library services for older Americans, the 1984 amendments added language to the Library Service Program—the core of the LSCA—which authorized the following services for the elderly: (1) Training librarians to work with older Americans; (2) conduction of special library programs for the elderly, specially those who are handicapped; (3) purchasing special materials for the elderly; (4) paying salaries of elderly persons who work in libraries as assistants in elderly library services programs; (5) providing in-home visits by librarians; (6) establishing outreach programs to alert the elderly about available services; and (7) furnishing transportation services.

The Carl D. Perkins Vocational Education Act [Public Law 98-524] represents a strong rejection of the administration's request to increase States' discretion in vocational education. Although the new bill reduced some of the planning requirements imposed on States, it also mandated new setasides—money earmarked for improving vocational programs. In a key change, the ability of States and schools to use Federal money to maintain existing programs was strictly limited. The bill included a provision which emphasizes using Federal funds for innovation and updating vocational programs. This requirement reflects Congress' interest in the improvement and modernization of vocational programs.

The act authorized $950 million for the program in fiscal year 1985 and such sums as may be necessary through fiscal year 1989. An amendment offered by Representatives Biaggi and Ratchford was included in the final measure which establishes a grant program for model centers to focus attention on the special vocational education needs of persons 55 or older and to promote employment opportunities for older Americans. The centers are directed to provide training in growth industries which offer promising job potential and to provide information, counseling, and support services to assist older persons in obtaining employment. The centers, however, received zero funding for fiscal year 1986. Federal funding accounts for only about 8 percent of all vocational education support.

For the third consecutive year, Congress passed a regular Labor, HHS, Education appropriations bill. On October 2, the House passed its fiscal year 1986 appropriations bill (H.R. 3424). The Senate passed its version of this bill on October 4. The subsequent House-Senate conference report (C. Rept. 99-402) was agreed to by the House on December 5, and the Senate on December 12, 1985 (Public Law 99-178). Under the spending bill, vocational education in fiscal year 1986 is funded at $838,814,000 and adult education is appropriated at $1,196,300.

For the fourth consecutive year, the administration proposed in 1986 to eliminate funding for the Department of Education library programs. Congress rejected this idea and appropriated $123 million for this program in fiscal year 1986, of which $80 million is directed toward public library services.

## 4. PROGNOSIS

Rapid technological change in our society is intensifying the need for lifelong learning, and is placing a greater emphasis on acquiring new job skills. A major consideration in the issue of educating and retraining older workers is the projected labor shortage in the coming decades. For those older workers who view early retirement as an opportunity to change career direction, this trend represents an opportunity to remain an active and productive members of the work force. The linkage between older workers and the labor market, however, will require a commitment of resources for education, career counseling, and training, which is unlikely to be available in the near future.

While the legislation passed in 1984 and 1985 reflected Congress' intent to support programs such as library services and adult education, the overwhelming majority of Federal dollars continues to fund programs for educationally disadvantaged children and youth. As part of their efforts to reduce Federal overhead, the Reagan administration has urged a reduced Federal role in education programs across the board. Thus, the intergenerational struggle that has emerged over scarce Federal resources between the burgeoning elderly population and historical benefactors—youth and children, will rest on such fundamental public policy issues as educational equity and access. The resolution of these critical issues will depend on the ability of each group to register their interests and demands with public policymakers at both the State and Federal level. On the other hand, it is very possible that by way of the Gramm-Rudman-Hollings approach to cutting the deficit, Congress may turn an equally deaf ear to all age groups.

In order to adequately address the educational needs of older persons, greater attention needs to be devoted to providing the supportive services, such as transportation and career counseling, which help older students enjoy successful learning experiences. Federal, State, local and private sector initiatives need to focus on the types of educational programs suitable for older persons, and action needs to be taken to increase participation for those older adults with less education, especially the illiterate. With the graying of America, now seems the appropriate time to refocus our educational programs, and commit our resources to enhancing the educational opportunities of older persons, as well as the young.

## D. OLDER AMERICAN VOLUNTEER PROGRAMS [OAVP]

### 1. Background

The Older American Volunteer Program [OAVP], which includes the Retired Senior Volunteer Program [RSVP], the Foster Grandparent Program [FGP], and the Senior Companion Program [SCP], is the largest of the ACTION Program components. For fiscal year 1985, OAVP funding constituted 69 percent of total ACTION funding, and continues to support the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 years of age and over to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies which recruit, place, supervise, and support older volunteers.

A significant facet of the OAVP is the extent to which Federal funding is supplemented by State and local resources. According to ACTION estimates, State funding to support ACTION-funded volunteer projects is estimated at over $16 million annually—$10 million for the FGP, and $3 million each for the Retired Senior Volunteer and Senior Companion Programs. In the past few years, State funds generated to support each of the programs have exceeded the Federal requirements for matching funds. ACTION estimates that States provide an average of 24 percent of total funds used under the FGP (compared to the requirement for 10 percent matching funds); and an average of 40 percent under the RSVP (compared to the Federal requirement for between 10 and 30 percent matching funds, depending on the age of the project). To a great extent, the fact that these projects continue to generate additional funding at the State and local level and are a cost-effective means of providing community services, has made them enormously popular with both Congress and the administration.

### (A) RETIRED SENIOR VOLUNTEER PROGRAM [RSVP]

RSVP was authorized in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on Aging to ACTION, and in 1973, the program was incorporated under title II of the Domestic Volunteer Service Act. The program is designed to provide volunteer opportunities for persons 60 years and over in a variety of community settings. In fiscal year 1985 there were approximately 365,000 RSVP volunteers in 751 projects; these volunteers are estimated to have generated more than 68 million volunteer hours. Volunteers serve in such areas as youth counseling, literacy enhancement, long-term care, crime prevention, refugee assistance, and housing rehabilitation. RSVP sponsors include State and local government, universities and colleges, community organizations, and senior service groups. Each project is locally planned, operated, and controlled. Although volunteers do not receive hourly stipends as under the Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses incurred as a result of their volunteer activities.

### (B) FOSTER GRANDPARENT PROGRAM [FGP]

The FGP program was originally developed in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was authorized under the Older Americans Act in 1969 and 2 years later transferred from the Administration on Aging to ACTION. In 1973, FGP was incorporated under title II of the Domestic Volunteer Service Act.

The FGP is designed to provide part-time volunteer opportunities for low-income persons 60 years and over to assist them in providing supportive service to children with physical, mental, emotional, or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day care centers, and institutions for the mentally or physically handicapped. Volunteers serve 20 hours a week and provide care on a one-to-one basis to three or four children. Under current law, a foster grandparent may continue to provide services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming 21.

Volunteers receive an hourly stipend, transportation assistance, an annual physical examination, insurance benefits, and meals when serving as volunteers. The Domestic Volunteer Service Act prohibits stipends from being subject to tax and from being treated as wages or compensation. Foster grandparent volunteers must have an income which is below the higher of 125 percent of the DHHS poverty guidelines, or 100 percent of these guidelines plus the amount each State supplements the Federal SSI payment. This annual income level was $6,565 for an individual in most States in 1985. In fiscal year 1985 there were approximately 19,000 FGP volunteers serving in 259 projects, including about 400 volunteers in 10 nonfederally funded projects. ACTION has estimated that about 66,000 children with special needs are served on a daily basis.

### (C) SENIOR COMPANION PROGRAM [SCP]

The SCP was authorized in 1973 by Public Law 93-113 and incorporated under title II, section 211(b) of the Domestic Volunteer Service Act of 1973. The Omnibus Budget Reconciliation Act of 1981 amended section 211 of the act to create a separate part C containing the authorization for the Senior Companion Program. This program is designed to provide part-time volunteer opportunities for low-income persons 60 years of age and over to assist them in providing supportive services to vulnerable, frail older persons. The volunteers assist homebound, chronically disabled older persons to maintain independent living arrangements in their own places of residence. Volunteers also provide services to institutionalized older persons. Senior companions serve 20 hours a week and receive the same stipend and benefits as foster grandparents. In order to participate in the program, volunteers must meet the same income test as described above for the Foster Grandparent Program.

In fiscal year 1985, about 5,900 SCP volunteers served in 112 projects, including 900 volunteers in 16 nonfederally funded projects. ACTION estimates that these volunteers served about 20,650 persons.

A new program component of the SCP was established as part of the 1984 amendments to the Domestic Volunteer Service Act. This legislation established authority for the Director of ACTION to make grants for homebound elderly projects to assist homebound elderly to remain in their own homes and to enable institutionalized persons to return to home care settings. Under this authority ACTION is authorized to make grant awards for the recruitment of volunteer trainers to instruct volunteers to participate in and monitor needs assessments and in-home services for elderly recipients of volunteer services. ACTION announced the availability of $3 million for grants to homebound elderly projects during fiscal year 1985. With these new funds, grants were awarded to 17 existing SCP projects to expand their services to the homebound: In addition, awards were made to 19 new projects. These grants are expected to support 912 volunteers serving 3,600 persons in 25 States during the first year of operation.

## 2. ISSUES

In recent years, there has been a strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in the society. Historically, voluntarism has been thought of as a commitment of time and resources to institutions and organizations such as hospitals, nursing homes, shelters for the homeless and abused, schools churches, and other social service agencies. In more recent years, volunteer service has included activities for grassroots political advocacy and community improvement programs.

The Federal role in encouraging voluntary efforts has been coordinated through the ACTION agency. ACTION was established in 1971 under a reorganization plan which consolidated seven existing volunteer programs into a single independent agency. ACTION was granted statutory authority in 1973 under the Domestic Volunteer Service Act, which repealed previous legislative authorities for the component programs and authorized several new volunteer activities. Programs authorized under DVSA and administered by ACTION include Volunteers in Service to America [VISTA], service learning programs, special volunteer programs, and the older American volunteer programs [OAVP]. Since its inception as a Federal program, ACTION agency volunteers have been involved in programs designed to reduce poverty, help the physically and mentally disabled, or serve in a variety of other community activities.

The need continues in many communities for volunteer efforts which address the problems of poverty and utilize the skills and experiences of those, notably the elderly. A central theme of the Reagan administration and a major focus of the President's Task Force on Private Sector Initiatives has been to encourage increased individual and corporate responsibility in meeting local economic and social service needs. As part of the President's new federalism initiatives, increased emphasis has been placed on shifting funding and management responsibility for many community services from the Federal level to the State and local governments, and to the private sector. For example, the administration has proposed eliminating the community services block grant—the community action program designed to provide services which have a measurable impact on the causes of poverty—and replacing it with initiatives to encourage the development of private sector antipoverty activities. Notably, reduced funding for the CSBG has resulted in greater reliance on volunteers rather than trained professionals to administer and implement services in the community. As this shift in Federal policy continues, greater pressure in helping to meet human needs will be directed toward the voluntary sector.

## 3. LEGISLATION

On December 12, 1985, the President signed into law fiscal year 1986 appropriations legislation for the OAVP [Public Law 99-178] as part of the appropriations for the Departments of Labor, Health and Human Services, and related agencies. The fiscal year 1986 appropriations for the OAVP are as follows: RSVP $29.62 million; FGP, $56.1 million; and SCP, $18.09 million. These levels are the same as those enacted for fiscal year 1985.

Authorizations of appropriations for the Domestic Volunteer Service Act expire at the end of fiscal year 1986; therefore the act will be reviewed during 1986. On October 29, 1985, the Subcommittee on Human Resources of the House Education and Labor Committee held an oversight hearing on the OAVP in preparation for review of these programs prior to consideration of reauthorization proposals.

## E. TRANSPORTATION

Transportation is the vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of the most basic needs; maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities. Housing, medical, financial, and social services are useful only to the extent that transportation can make them accessible to those in need. Transportation serves both human and economic needs. It can enrich an older person's life by expanding opportunities for social interaction and community involvement, and it can support the individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

### 1. BACKGROUND

Three strategies have marked the Federal Government's role in providing transportation services to the elderly: Direct provision—funding capital and operating costs for transit systems, reimbursement for transportation costs, and fare reduction. As part of the "new federalism" initiative, the Reagan administration has proposed in fiscal years 1981-85 to eliminate or substantially reduce Federal operating subsidies to States for transportation programs. This proposal was indicative of the trend to shift fiscal responsibility for transportation programs to the States and of a general retrenchment on the part of the Federal Government to support further transportation systems.

The major federally sponsored transportation programs that provided assistance to the elderly and handicapped are administered by the Department of Health and Human Services [DHHS] and the Department of Transportation [DOT]. Under DHHS, a number of programs provide specialized transportation services for the elderly. These inlcude title III of the Older Americans Act, the social services block grant, the community services block grant, and to a limited extend Medicaid, which will reimburse elderly poor for transportation costs to medical facilities. Under the CSBG, more dollars are spent on so-called linkages with other programs—including transportation for the elderly and handicapped which links clients to senior centers, community and medical services, than on any other program category—over $80 million in fiscal year 1983.

The passage of the Older Americans Act [OAA] in 1965 has had a major impact on the development of transportation for older persons. Under title III of the OAA, States are required to spend an adequate proportion of their title III-B funds on three categories: Access services (transportation and other supportive services); inhome, and legal services. In fiscal year 1983, transportation services alone comprised 9.4 percent of area agency on aging total service expenditures. This level of spending is a clear indication of the demand for transportation services by the elderly at the local level and the extent to which this network of supportive services provides assistance and relief to needy elderly nationwide.

The passage of the 1970 amendments to the Urban Mass Transit Act of 1964, section 16(a) and 16(b) (Public Law 98-453), marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifyng transportation facilities for improved access by the elderly and handicapped. Section 16 of UMTA declares it to be the national policy that elderly and handicapped persons have the same rights as other persons to utilize mass transportation facilities and services; that special efforts shall be made in the planning and design of mass transportation facilities and services so that the availability to the elderly and handicapped persons of mass transportation is assured; and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. Essentially, the goal of section 16 programs is to provide assistance in meeting the transportation needs of elderly and handicapped persons where public transportation services are unavilable, insufficient, or inappropriate.

Another significant initiative in the last decade was the enactment of the National Mass Transportation Assistance Act of 1974 [Public Law 93-503] which amended UMTA to provide mass transit funding for urban and nonurban areas nationwide through block grants. Under the program, block grant money can be used for capital operating purchases at the localities' discretion. The act also requires transit authorities to reduce fares by 50 percent for the elderly and handicapped during offpeak hours. Also, passage of the Surface Transportation Assistance Act of 1978 provided funding at the Federal level to support public transportation program costs, both operating and capital, for nonurbanized areas. Programmatic changes to these provisions were made through the Surface Transportation Act of 1984 [Public Law 97-424] which reauthorized UMTA.

The programs administered by DHHS have proved highly successful in providing limited supportive transportation services necessary for linking needy elderly and handicapped persons to social services in urban and suburban areas. The DOT programs have been the major force behind mass transit construction nationwide and continue to provide basic funding sources for primary transportation services for older Americans. Despite these program initiatives, the Federal strategy in transportation remains essentially one of providing seed money for local communities to design, implement, and administer transportation systems unique to their individual needs and resources. In the future, the Federal response to the increasing need for specialized services for the elderly and handicapped will dictate the range of services available and to a large extent, the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

## 2. Issues

### (A) TRANSPORTATION FOR THE RURAL ELDERLY

Transportation was cited as one of the major barriers facing the rural elderly in a report published by the Senate Special Committee on Aging in September 1984. According to the committee report, an estimated 7 to 9 million rural elderly lack adequate transportation and as a result, are severely limited in their ability to reach needed services. The isolation of rural areas, along with the more limited availability of resources and uncertainty of institutional support, makes the transportation problems of rural elderly more acute than their urban counterparts. Roads are sometimes narrow and poorly paved, further hampering travel for the rural elderly. Also, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of volunteers willing to transport the rural elderly. Lack of access to transportation in rural areas leads to an underutilization of programs specifically designed to serve older persons, such as adult education, congregate meal programs, and health promotion activities. Thus, the problems of service delivery to rural elderly are essentially problems of accessibility, not program design.

Lack of transportation for the rural elderly stems from several factors. First, the dispersion of rural populations over relatively large areas, complicate the design of a cost-effective, efficient public transit system. In addition, the incomes of the rural elderly generally are insufficient to afford the high fares which are necessary to support a rural transit system. Further, the physical design and service features of public transportation, such as high steps, narrow seating, and unreliable scheduling discourage participation by the elderly.

Generally, Federal transportation policy has not recognized the specialized needs of rural elderly. In an effort to draw attention to these critical transportation issues, specific recommendations were made during the 1981 White House Conference on Aging directed at improving rural transportation for the elderly. A miniconference on transportation for the aging which preceded the general conference recommended that State transportation agencies play a central role in developing responsive rural systems, with implementation for such a system initiated at the local level in order to ensure appropriate design for the unique needs of the individual community. The conference also recommended greater citizen participation at the policymaking level as well as at the advisory and implementation levels of transportation programs.

### (B) TRANSPORTATION FOR THE SUBURBAN ELDERLY

The graying of the suburbs is a phenomenon which has only recently received attention from policymakers in the aging field. Since their development following World War II, it has been assumed that the suburbs consisted mainly of young, upwardly mobile families. The decades that have elapsed since that time have changed entirely the profile of the average American suburb; the suburbs have aged with profound implications for social service design and delivery. In 1980, for the first time a greater number of persons over age 65 lived in the suburbs, 10.1 million, than in central cities, 8.1 million.

The availability of transportation services for the elderly suburban dweller is limited. Unlike large metropolitan cities where dense population patterns can facilitate central transit systems, the lack of a central downtown precludes development of a coordinated mass transit system in most suburbs. The sprawling geographical nature of suburbs makes the cost of developing and operating mass transportation systems prohibitive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has impacted significantly on the development of transportation services generally. Consequently, Federal support for primary transit systems designed especially for the elderly suburban dweller is almost nonexistent, and consists mostly as a supportive service. State and local governments have been unable to harness sufficient resources to fund costly transportation systems independent of Federal support. Often, alternative revenue sources are not politically expedient. For example, user fees alone are insufficient to support suburbanwide services and are generally viewed as penalizing those persons who are in most need of transportation services in the community—the elderly poor.

In 1984, researchers at the State University of New York in Albany received a grant from the National Institute of Child Health and Human Development to study the implications of older suburban populations on public policy, including transportation services. Their studies show that suburbs with a larger number of elderly have adjusted to the needs of their dependent population by providing substantially higher levels of municipal services than the typical suburb. However, this has been accomplished through a heavy reliance on high property taxes. The fact that communities with the greatest demand for services for the elderly are precisely the communities that lack a tax base to support these expenditures has intensified the fiscal squeeze; many have already reached the constitutional limit on taxing authority. Thus, other sources of revenue are being tapped, such as lotteries and user fees, to help fund these additional community services.

The fact that the suburbs have aged has several implications for transportation policy and the elderly. The dispersion of older persons over a suburban landscape poses a unique challenge for community planners who have specialized in providing services to younger, more mobile dwellers. Transportation to and from service providers is a particularly critical need. Institutions which serve the needs of the elderly persons, such as hospitals, senior centers, and convenience stores must necessarily be designed with supportive transportation services in mind. Further, service providers must provide transportation services for their elderly clients. Primary transportation systems, or mass transit, must ensure accessibility from all perimeters of the suburban community in order to adequately serve the dispersed elderly population. The demand for transportation services should be measured to determine the feasibility of alternative systems such as dial-a-ride and van pools. Alternative funding mechanisms such as reduced fares, user fees, and the local tax based need to be examined for equity and viability. Also, the public should be informed of the transportation services available through a coordinated public information network within the community.

The aging suburb trend will increase in the decades to come. It is clear that to the degree that the elderly are denied access to transportation, they are denied access to social services. If community services are to meet the growing social and economic needs for the older suburban dweller, transportation planning and priorities will demand reexamination.

### 3. LEGISLATION

Funding was provided for fiscal year 1986 for the Department of Transportation and related agencies, by way of a continuing resolution, which passed on December 19, 1985 [Public Law 99-190]. Funding was set at $10.455 billion, a $1.55 billion decrease from fiscal year 1985. This funding level includes $30.5 million for Federal mass transit funds to States for transportation assistance for elderly and handicapped persons, including such capital expenses as buses, vans, wheelchair lifts, and communications equipment. This represents a $4.5 million increase.

Both the House and Senate passed versions of H.R. 3244 [S. Rept. 99-152] to appropriate funds for the Department of Transportation for fiscal year 1986, but the conference had not met by the December 1985 adjournment.

### 4. PROGNOSIS

The demographic and social changes anticipated in the coming decades will have profound implications for planning and implementing social services for the elderly, particularly transportation programs. According to a report on transportation and the elderly, published by the Department of Transportation in April 1983, the implications of social and demographic changes on future transportation policy include:

> The demands of the elderly for specialized transportation will increase in the 1980's. This is apparent from the sheer rise in the numbers of older people, and in the expected increased costs of fuel, the increase in costs of purchasing and owning an automobile, and an established and growing demand for mobility among the elderly.
>
> Most of the riders of specialized transportation services are likely to be female, of advanced age, and drawn from minority groups. The economic position of about one-sixth of the aging population, approximatly 5 million persons, will constitute the core group which are likely to be transportation disadvantaged, in the full sense of that term and candidates for specialized transportation services.
>
> Specialized transportation programs will need to consider serving an older, probably less physically able population than heretofore. The marked growth of the 95 years and older population will place increasing demands on the specialized transportation network. That network will need to take into account a group of riders who will have some difficulty in walking yet want to maintain a measure of mobility and independence.

In view of increasingly limited Federal participation in transportation services, the role that State and local governments play in this area will become of major significance to needy elderly and handicapped persons. States will need to reassess priorities with attention toward replacing Federal funding through increased State or local taxes or simply eliminating certain services. Although private sector contributions have played a significant role in social service delivery, it is unlikely that this revenue source will be adequate to close the gaps opened by Federal budget cuts in the area of specialized transportation services. Another resource—volunteer activities—has always been important in terms of the provision of transportation services to older Americans. A report undertaken before the Administration on Aging on the transportation problems of older Americans indicated that many agencies servicing the elderly already use volunteers extensively in their programs. Given the stringency in resources which may be anticipated over the next decade, efforts to increase the role of volunteers are likely to become increasingly important.

The trend toward block grant programs implies a broader range of roles and reinforces the need for advanced system planning and priority service setting at the State and local level. Since block grant programs are linked with absolute funding levels, and since programs funded by discretionary appropriations from general revenues are becoming particularly vulnerable, the relationship between individual State and local governments will need to be better defined if cooperative fiscal efforts by these jurisdictions are to function successfully. Until these relationships are clarified and secured, access by older Americans to the array of community services may continue to be severely hampered.

## F. LEGAL SERVICES

Older persons, because of difficulties of access and unique legal problems, have a special need for legal services. This is primarily a result of the low-income status of many older persons and the complex nature of the programs upon which the elderly are so dependent. After retirement, most older Americans are dependent upon Government-administered benefits and services for their entire income and livelihood. For example, many elderly persons rely on the Social Security Programs for income security and on the Medicare and Medicaid Programs to meet their health care needs. These benefit programs are extremely complicated and often difficult to understand for persons inexperienced with government.

In addition to governmental benefits, legal problems of older persons typically relate to consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to an institution, nursing home and probate matters. Legal services and professional legal representation by those who know the law are of vital importance to the elderly because it helps them to obtain basic necessities and assures that they receive benefits and services to which they are entitled and for which they have worked all their lives.

Unfortunately, older persons encounter special problems in gaining access to legal services. A large number of older persons, particularly those who qualify for many benefit programs, cannot afford to hire a private attorney. Others are not comfortable accepting free- or low-cost legal services and others are simply wary of dealing with members of the legal profession. In addition, many older persons may fail to recognize some of their problems as legal problems and may not be aware of existing legal services. Finally, many older Americans face specific barriers to legal services because of lack of transportation, physical handicaps, fear of crime, and difficulty in communication.

The national population segment from which the need for elderly legal services arises is large and growing. Private bar efforts alone fall far short in providing for the needs of older Americans for legal help. In addition to legal services provided by the private bar, a number of existing Federal programs provide legal services for older persons. Programs funded under the social services block grant established under the Omnibus Reconciliation Act of 1981, the Older Americans Act [OAA], and the Legal Services Corporation are among these programs. Of these three, the Legal Services Corporation [LSC] is the largest provider of legal services to low-income elderly.

While everyone agrees that provision of legal services to the elderly is vital, there has been a controversy as to which legal services should be provided and how best to provide them. This dispute was touched off in 1981 when President Reagan proposed to terminate the federally funded Legal Services Corporation. The broad controversy surrounding the provision of legal assistance to the poor can be seen in the history of the Legal Services Corporation and has been played out in the funding, authorization, and nomination process for the Corporation. While the controversy still goes on, it is significant that Congress has consistently opposed President Reagan's proposals to abolish the LSC.

## 1. BACKGROUND

### (A) THE LEGAL SERVICES CORPORATION

Legislation creating the Legal Services Corporation (LSC) was enacted in July 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act in 1966. President Nixon, however, recognized that because some of the litigation initiated by legal services brought it in direct conflict with local and State governments and because the program was concerned with social issues, it was subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, he requested legislation creating a separate, independently housed corporation. The Legal Services Program was then established as a private, nonprofit corporation headed by an 11-member board of directors, nominated by the President and confirmed by the Senate.

The Corporation does not provide legal services directly; rather, it funds local legal aid projects. Each local legal service project is headed by a board of directors, of which 60 percent are lawyers who have been admitted to a State bar. The Corporation also funds a number of national support centers, which develop and provide specialized expertise in various aspects of poverty law to legal services attorneys in the field.

Legal services provided through Corporation funds are available only in civil matters and to any individual with an income no higher than 125 percent of the Office of Management and Budget poverty guidelines. The Corporation places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine legal problems of low-income people. According to the Corporation's 1985 annual report, almost one-third of legal services cases are family related, such as divorce and separation, child custody and support, and adoption. Another 19 percent of legal services cases deal with housing problems, primarily landlord-tenant disputes in non-Government subsidized housing. Problems with welfare or other income maintenance programs, and consumer and finance problems, form the next two largest categories of legal services cases. Individual rights, employment, health, juvenile, and education cases make up the remaining caseload. Most cases are resolved outside the courtroom.

At the national level, the LSC has funded national support centers which provide support to field attorneys and State support centers. Four of these centers are specifically involved in issues that confront older people. They are: the National Senior Citizens Law Center [NSCLC], in Los Angeles, CA, and Washington, DC; Legal Counsel for the Elderly [LCE], in Washington, DC; and Legal Services for the Elderly [LSE] in New York City, NY.

Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several others have been added since then. Most of the restrictions were made in response to the critics of the program who charge that legal services funds have been used to promote the social and political goals of activist attorneys, in the guise of providing legal assistance to the poor. They believe that although legal services attorneys are theoretically prohibited from pursuing their own political and social interests by a requirement that they must be representing a particular client before getting involved in an issue, this requirement is easily circumvented without specific restrictions. The current restrictions include a prohibition on cases dealing with school desegregation, nontherapeutic abortions, certain violations of the Selective Service Act, and Armed Forces desertion. The appropriations measure currently in effect contains further prohibitions against lobbying with Corporation funds, representing aliens who don't meet specified conditions, and class action suits against Federal, State, or local governments except under certain circumstances.

Other restrictions were placed in the regulations by supporters of legal services who were concerned that the broad scope of the Corporation's work would be sharply curtailed by its detractors. For example, the current appropriations measure also prohibits board members who have not been confirmed by the Senate from reducing current grants. One restriction places limits on the amount of pay board members may receive and the type of fringe benefits employees may be given. This restriction stems from a controversy which arose in late 1982 concerning what were thought by some to be excessive consultant and travel fees received by the board of directors. Another restriction prohibits use of funds to issue new regulations or to enforce those effective after April 27, 1984, unless the House and Senate Appropriations Committees have been notified 15 days in advance. This restriction was added in response to concerns that proposed regulations issued by the LSC, such as those curtailing legislative and administrative advocacy by LSC attorneys on behalf of poor clients, would drastically change existing policy within the Corporation.

### (B) OLDER AMERICAN ACT

Support for legal services under the Older Americans Act [OAA] was a subject of interest to both the Congress and the Administration on Aging [AoA] for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were among those made at the 1971 White House Conference on Aging. Regulations promulgated by the AoA in 1973 identified, for the first time, legal services as eligible for funding under title III of the OAA. Amendments to the OAA, in 1978, established a funding mechanism and a programmatic structure for legal services. Area agencies on aging are required by the Older Americans Act to allocate an adequate proportion of title III supportive services funds for legal assistance. The 1984 amendments to the act added a requirement that area agencies annually document the amount of funds expended for this assistance. The act also requires that area agencies contract with legal assistance providers which can demonstrate the experience or capacity to deliver legal assistance and to involve the private bar in legal assistance activities. Where the legal assistance grantee is not a Legal Service Corporation grantee, that provider is required to coordinate services with LSC-funded programs in its area.

Unfortunately, the total amount of title III funds expended on legal services for recent fiscal years is not available. As part of its past efforts to reduce State reporting burdens, AoA discontinued the requirement that States report expenditure data on types of services. The Legal Services Corporation, however, reported that it received $10.2 million in OAA monies in 1985. According to the AoA Fiscal Year 1984 Program Performance Report, the total number of persons who received legal services was 490,405 persons.

The OAA requires State agencies on aging to establish and operate a long-term care ombudsman program which, among other things, investigates and resolves complaints made by or on behalf of older residents of long-term care facilities. The 1981 amendments to the OAA expanded the required scope of the ombudsman program to include board and care facilities. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AoA has stressed the importance of such a relationship and has provided grants to States designed to further ombudsman, legal and protective services activities for older people and to assure coordination of these activities. State ombudsman reports indicate that through both formal and informal agreements, legal services, attorneys and paralegals help ombudsmen: Secure access to facilities, residents, and residents' records; provide consultation to ombudsman on law and regulations affecting institutionalized persons; represent clients referred by ombudsman programs; and work with ombudsmen and others to bring about changes in policies, laws, and regulations to benefit older persons in institutions.

### (C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, provide services directly or contract with public and nonprofit social service agencies for providing social services to persons and families. States, for the most part, determine which social services to provide and for whom they shall be provided. Services may include legal aid. Because many of the reporting requirements previously included in the title XX program, have been eliminated, very little information is available on how States have responded to both funding reductions and changes in the legislation. Thus, there is no information available on the number of persons or the age breakdown of those persons who are being served.

## 2. ISSUES

### (A) NEED AND AVAILABILITY OF LEGAL SERVICES

The need for civil legal services for the elderly, especially the poor elderly, is undeniable. Federal legal services reporting systems count older persons on the basis of those over the age of 60. Over 36 million Americans were over 60 in 1982, or roughly 16 percent of the population. Persons over 60 constitute 14.6 percent of all persons below the official Government poverty line. This is approximately 5 million persons. Under current eligibility requirements, individuals with incomes up to 125 percent of the poverty line may be eligible for LSC funded legal assistance. Using this standard, approximately 8.7 million persons over the age of 60 are LSC eligible persons. Unfortunately, there is no precise way of determining eligibility for legal services under the Older Americans Act since eligibility is based both upon economic and social need, and means testing for eligibility is prohibited. An expert in the field has stated that if one were to consider the potential clientele for Older Americans Act legal services as those realistically unable to afford legal assistance, a majority of older persons would qualify for such assistance. Fully two-thirds of persons over 65 in 1980 had incomes of less than $8,000 per year. Of older persons over 65 and living alone, more than 60 percent had annual incomes of less than $7,000. It is clear that a substantial percentage of older persons are poor or near poor and would find it difficult to purchase legal representation.

LSC programs handled and closed 1,227,358 cases in fiscal year 1984. Although programs funded under the Legal Services Corporation Act make services available to all low-income persons, persons 60 years of age and older constitute a sizable portion of the client eligible population. Thirteen percent, or 175,188 cases handled in 1984 involved a client age 60 and over. This figure represents a decrease over the 1982 level of 14 percent.

An essential component of legal services delivery systems for the elderly is the private bar. The expertise of the private bar is considered especially important in such areas as wills and estates, real estate and tax planning. Many elderly persons cannot obtain legal services because they cannot afford to pay customary legal fees. In addition, a substantial portion of the legal problems of the elderly stem from their dependence on public benefit programs. The private bar is generally unable to undertake representation in these matters because it requires familiarity with a complex body of law and regulations, with little chance of generating a fee for services rendered. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, low-fee, or no-fee (pro bono) basis, the potential of the private bar to serve the elderly in need of legal assistance has not yet been fully realized.

The availability of legal representation for low-income older persons is also determined, in part, by the availability of funding for legal services programs. In recent years, there has been a trend to cut Federal dollars provided to local programs for the delivery of elderly legal services. There is no doubt that older persons are finding it more difficult to obtain legal assistance. When the Legal Services Corporation was established in 1975, its foremost goal was to provide all low-income people with at least minimum access to legal services. This was defined as the equivalent of two legal services attorneys for every 10,000 poor people. In contrast, in 1975 there were approximately 11.2 lawyers for every 10,000 persons above the Federal poverty line. In fiscal year 1980, the goal of minimum access was achieved with an appropriation of $300 million. Currently, however, the LSC is not funded to provide minimum access to legal assistance for poor persons. In most States, only one attorney serves 10,000 poor persons. To meet the minimum access level, the National Legal Aid and Defender Association estimated that the Corporation would need a fiscal year 1985 budget of $470 million.

In 1981, Congress first reduced the funding to the LSC by 25 percent (from $321 million to $241 million). This funding reduction translated in the immediate loss of 1,793 attorneys and the closing of more than 108 local offices, making it more difficult for older persons with legal needs to gain access to legal representation. At the start of 1985, there were 324 legal services programs throughout the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. The number of field program offices at the start of 1985 was 1,310, down from 1,475 in 1981. At the end of 1984, the LSC employed 4,767 attorneys, as compared to 6,559 in 1980.

Cuts in funding also coincided with a national economic recession creating a category of "new poor" and changes in Federal programs creating new legal needs for the poor. Since 1981, there have been further reductions in the LSC's ability to meet their clients' legal needs. Legal services field offices report having to scale down their operations and narrow their priorities to focus attention on emergency cases, such as evictions or loss of means of support. Legal services offices must not make hard choices about which poor persons will be denied service and which will receive legal attention. A 1984 survey of LSC field offices stated that three-fourths of the responding programs believed that the level of unmet legal needs was greater than it had been in 1982 and only 13 percent of the programs believed that they met a greater amount of legal need in 1983 than in 1982.

### (B) ALTERNATIVE PROVIDERS

Few people disagree that the provision of legal services to the elderly is important and necessary. Yet there has been continuing controversy as to how best to provide these services. This dispute was touched off again when President Reagan proposed in 1981 to terminate the federally funded Legal Services Corporation and to include legal services activities in a social services block grant. Funds then going to the Corporation, however, were not proposed for inclusion in the block grant. The block grant approach is consistent with the administration's goal of consolidating categorical grant programs and transferring decisionmaking authority to the States. Inclusion of legal services as an eligible activity in block grants, it was argued, would give States greater flexibility to target funds where the need is greatest and that allowing States to make funding decisions regarding legal services would make the program accountable to elected officials.

At the time of this proposal, the administration revived earlier charges that legal services attorneys are more devoted to social activism and to seeking collective solutions and reform than to routine legal assistance for low-income individuals. These charges renewed the controversy surrounding the program at the time of its inception as to whether Federal legal aid is being misused to promote liberal political causes. The poor often share common interests as a class, and many of their problems are institutional in nature, requiring institutional change. Because legal resources for the poor are a scarce commodity, legal services programs have often taken group-oriented case selection and litigation strategies as the most efficient way to vindicate rights. The use of class action suits against the Government and businesses to enforce poor peoples' rights have angered officials. Others protest against the use of group orientation methods on the basis that the poor can be protected only by allocation and litigation procedures which treat each poor person equally as a unique individual and not by procedures which weigh group impact. As a result of these charges, the ability of legal services attorneys to bring class action suits has been severely restricted. Of the 1,271,473 LSC cases closed in 1983, only 1,830 class action suits were reported.

President Reagan also justified his proposal to terminate the Legal Services Corporation by stating his belief that added pro bono efforts by private attorneys could substantially augment legal services funding provided by the block grant. The administration noted that elimination of restrictions on advertising by attorneys would increase the availability of low-cost legal services. They pointed to a congressionally mandated study which found legal services provided by private attorneys to be as effective as those provided by staff attorneys hired directly by local legal services programs. Their approach would allow States to choose among a variety of service delivery mechanisms, including reimbursement to private attorneys, rather than almost exclusive use of full-time staff attorneys supported by the Corporation. Finally, the administration argued that regardless of the continued existence of LSC, some funding is available at the State and local level for civil legal assistance to truly needy individuals. Over $50 million in funds, they say, is available through the Older Americans Act, under the social services block grant, and from a variety of public and private sources.

Supporters of federally funded legal services programs argue that neither State nor local governments nor the private bar would be able to fill the gap in services created by abolition of the LSC. They cite the inherent conflict of interest and the State's traditional nonrole in civil legal services which, they say, makes it unlikely that States will move forward to provide effective legal services to the poor. Many feel that the voluntary efforts of private attorneys cannot be relied on, especially when more lucrative work beckons. They believe that private lawyers have limited desire and ability to do volunteer work. Some feel that, in contrast to the LSC lawyers who have expertise in poverty law, private lawyers are not as likely to have this experience nor are they as likely to have the interest in dealing with the systematic abuses that poor people encounter.

Defenders of LSC say that the need among low-income people for civil legal assistance exceeds the level of services currently provided by both the Corporation and the private bar. One author has concluded that only about 15 percent of the legal problems of the poorest segment of the population receive any kind of legal attention. Elimination of the Corporation and its funding could further impair the need and the right of poor people to have access to their government and to the whole system of justice. They contend that it is also inconsistent to assure low-income people representation in criminal matters, but not to provide them with legal assistance in civil cases.

## 3. RESPONSES

### (A) LEGISLATION

### *(1) The Legal Services Corporation*

The LSC Act was reauthorized in 1977 for 3 additional years. At that time, much of the controversy surrounding the program, which grew from a perception that the program was one of social activism and reform rather than routine legal assistance, had abated. Since the early 1980's, however, the controversy as to whether Federal legal aid money is being misused to promote liberal political causes has re-emerged. This is due, in part, to the fact that every year since 1981, the Reagan administration has announced plans not to seek reauthorization of the program and has requested no funding for it. Congress, however, has rejected these proposals and has responded with bipartisan support to restore funding.

Funding for the LSC in its first year was $92.3 million. It rose to its highest level of $321.3 million in 1981. Since then, however, funding for LSC has been reduced. In fiscal year 1982, funding for the Corporation was cut by 25 percent to $241 million. This level was maintained in 1983. In 1984, $275 million was appropriated for the LSC [Public Law 98-107]. For fiscal year 1985, President Reagan again proposed to eliminate the Legal Services Corporation. The Corporation itself, however, requested $325 million. Congress passed and the President signed a measure [Public Law 98-411] providing fiscal year 1985 funds for a number of Federal agencies, including $305 million for the LSC. All restrictions in effect in fiscal year 1984 continued to apply. Further, the legislation specified that no grantee or contractor which received funds from the LSC in fiscal year 1984 may be denied refunding because of activities which an independent hearing officer, appointed by the LSC President, does not consider as grounds for denial of refunding.

Further provisions in Public Law 98-411 earmarked $2 million to the LSC to increase quality legal services to the elderly by: (1) Developing classroom and bar association source materials on law affecting the elderly for use by law schools, the private bar, legal services grantees, and in continuing education seminars; (2) developing plans to encourage to do more to provide better pro bono services for elderly and higher quality legal services; and (3) developing a clinical program to supplement local Legal Services Corporation grantees. The project also had to plan for the dissemination of results from the funded projects. In implementing this project, the Corporation solicited proposals nationwide. After extensive review, LSC granted $1.6 million to a total of 20 law school clinics, $140,000 for the development of six sets of source materials, and $222,820 to a total of 11 private bar pro bono projects. The projects were funded in 1985 by the Elderlaw project and will continue operation over a 2-year period.

On June 12, 1985, the House passed H.R. 2577, a supplemental appropriation for fiscal year 1985, containing $4 million for the establishment of a new poverty law center in New Orleans. The appropriation would be made to the LSC. The Senate version, passed June 20, also contained this $4 million, plus an additional $4 million for a legal clinic at the Drake University School of Law in Des Moines, IA. The final version of H.R. 2577 contains a total of $8 million for the two programs, to be funded through the LSC, bringing total LSC funding in fiscal year 1985 to $313 million. This bill was signed into law on August 15, 1985 (Public Law 99-88).

President Reagan requested no funding for the Legal Services Corporation for fiscal year 1986, but the Corporation requested $305 million. On July 17, 1985, the House passed H.R. 2965, a fiscal year 1986 spending bill for the Departments of State, Commerce, Justice, Judiciary, and related agencies, which included $305 million for LSC. On November 1, the Senate passed its version of H.R. 2965, containing $306.4 million for LSC. The Senate committee report recommended no further funding for the Elderlaw Program, which it said was intended to receive a one-time only appropriation. A conference report was subsequently approved and the measure was signed into law by the President on December 14, 1985 [Public Law 99-180]. It appropriates $305.5 million for the LSC for fiscal year 1986. In addition, the bill states that all restrictions and limitations applicable to the LSC in fiscal year 1985 would continue to apply and it restored certain cuts anticipated by the Corporation for the national support center program, migrant programs, and supplemental field programs.

During the summer of 1981, the appointments of all 11 LSC board members appointed by former President Carter had expired. President Reagan, however, did not appoint new members of the board until December 1981, after it became apparent that his proposal to terminate the Corporation would not be accepted. Between 1981 and 1984, he appointed a succession of people to the board on an interim basis. Because these appointments were made while Congress was in recess, they could serve without any Senate confirmation. During the same period, President Reagan announced a number of prospective nominees, but none were confirmed by the Senate. Some of them were opposed by liberals and moderates who questioned their qualifications and their commitment to legal services to the poor. Reports in 1982 that LSC board members were receiving extraordinarily large consulting fees for their services and that the LSC president was given unusually generous fringe benefits further affected the nomination process. In 1984, President Reagan granted recess appointments to 11 individuals he had unsuccessfully nominated earlier in the year. These people served without Senate confirmation, until the end of 1985. The names of these individuals, however, were also formally resubmitted to the Senate on January 3, 1985, when the Congress convened. Although a couple of the nominees were controversial and faced stiff opposition, all of them were approved by the Senate Labor and Human Resources Committee and subsequently by the full Senate on June 12, 1985.

### *(2) Older Americans Act*

In the past, AoA made separate grant awards to all States from title IV funds for legal services and ombudsman activities. A 1984 amendment to the Older Americans Act changed the process of allocation of funds for legal and ombudsman services as well as for State agency on aging administration and State education and training activities, effective in fiscal year 1985. Prior to fiscal year 1985, State agencies on aging received separate awards of funds for various administrative activities from both title III (through a separate allotment of funds for administration), and from title IV grant funds for legal serivces and ombudsman activities and for State education and training activities. The 1984 amendment merged these various streams of funding and consolidated under title III State agency administration those portions of the State agency activities which had been funded out of title IV funds, namely, legal services and ombudsman activities and State education and training activities. During passage of the amendment, Congress gave assurances that States would not receive any less in fiscal year 1985 funding from all these sources than they had received in fiscal year 1984. Congress intended that separate awards of title IV funds for legal services and ombudsman activities (and for State education and training) continue to be made to states which would not receive their 1984 "hold harmless" amounts. Because of the implementation of this new provision in fiscal year 1985, AoA awarded from title IV funds $1.9 million to 31 States and territories for legal services and ombudsman activities. The remaining 26 States received a sufficient increase in their consolidated funding amounts (after application of increases in title III appropriations) for State administration, legal services, ombudsman activities (and for State education and training activities) that separate awards of title IV funds were not necessary.

Four national organizations have received grants from the Administration on Aging to strengthen and support the provision of legal services for older persons. These organizations are: (1) Legal Counsel for the Elderly (sponsored by the American Association of Retired Persons), to provide training for legal services providers, legal services developers bar associations and other advocates and to offer assistance in the recruitment and use of volunteers; (2) the American Bar Association's Commission on Legal Problems of the Elderly, to offer assistance in the delivery of legal services to the elderly through private bar involvement and to provide information and assistance to the aging network in two specific legal areas (home equity conversion and quality assurance in home care); (3) the Center for Social Gerontology, to provide evaluation materials and substantive law training materials; and (4) the National Senior Citizens Law Center, to provide the aging network with substantive law support on legal problems of individual older persons and groups of older persons, to operate a computer assisted legal research clearinghouse on legal assistance for the elderly, and to develop evaluation tools and techniques for legal services.

### *(3) Social Services Block Grant*

In fiscal year 1875, contributions from the social services block grant for the provision of legal services totaled close to $10 million. This represents a decrease over the fiscal year 1983 figure of $12 million.

### (B) ACTIVITIES OF THE PRIVATE BAR

To counter the effects of cuts in Federal legal services and to ease the pressure on overburdened legal services agencies, some law firms and corporate legal departments have begun to devote more of their time to the poor on a pro bono basis. These programs are in conformity with the lawyer's code of professional responsibility which requires every lawyer to support the provision of legal services to the disadvantaged. While such programs are gaining momentum, there is no precise way to determine the actual number of lawyers involved in the volunteer work, the number of hours donated, and the number of clients served. Most lawyers for the poor say that these efforts are not yet enough to fill the gap and that a more intensive organized effort is needed to motivate and find volunteer attorneys. This assessment is noteworthy in light of the fact that President Reagan has justified his desire to abolish the LSC by saying that legal services for the poor could be provided more efficiently by members of the private bar.

A recent development in the delivery of legal services by the private bar has been the introduction in the United States of the Interest on Lawyers' Trust Accounts [IOLTA] program. This program allows attorneys to pool client trust deposits in interest-bearing accounts. The interest generated from these accounts is then channeled into federally funded, bar affiliated, and private and nonprofit providers of legal services. Thirty-nine States have already adopted some form of IOLTA and a reported $20 million has already been raised through this program across the country. The Legal Services Corporation reported receiving $2.6 million through IOLTA in 1985. An American Bar Association study group estimated that if the plan was adopted on a nationwide basis, it could produce up to $100 million a year. Supporters of the concept believe that there is no cost to anyone with the exception of banks, which participate voluntarily. Critics of the plan contend that it is an unconstitutional misuse of the money of a paying client who is not ordinarily apprised of how the money is spent. While there is no unanimity at this time among lawyers regarding IOLTA, it appears to have potential value as a needed funding alternative.

Another innovative idea is a legal hotline project which is being tested by Legal Counsel for the Elderly (LCE), a department of the American Association of Retired Persons. LCE was awarded a major grant from the Administration on Aging to create a free telephone legal advice and referral service for older people. The prototype, which became operational in June 1985, will serve the large metropolitan area of Pittsburgh, PA. If successful, the hotline will be expanded to a statewide service area and could be replicated in other States. The major source of funding for the project will come from the law firms who receive the referrals and from the sale of wills.

In 1977, the then-president of the American Bar Association (ABA) was determined to add the concerns of senior citizens to the ABA's roster of public service priorities. He designated a task force to examine the status of legal problems and the needs confronting the elderly and to determine what role the ABA could play. Based on a recommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly was established by the ABA in 1978. The commission was charged with examining four priority areas—provision of legal services to the elderly, discrimination against the elderly, simplicification and coordination of administrative procedures and regulations, and issues involving long-term care. Subsequently, two new priority areas were added: Housing and Social Security. Since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

The commission has undertaken many activities to promote the development of legal resources for older persons and to involve the private bar in responding to the needs of the aged. One such activity is the national bar activation project which provides technical assistance to State and local bar associations, law firms, corporate counsel, legal service projects, the aging network, and other in developing projects for older persons. It aims to generate pro bono, reduced-fee referral, and community education programs for senior citizens, as well as relevant continuing legal education curriculums for attorneys. In addition, the project publishes a quarterly newsletter, Bifocal; acts as a clearinghouse for private bar activities to assist the elderly, and seeks to implement models which afford maximum cooperation among legal services projects, the private bar, and the Older Americans Act network of State and area agencies on aging.

The ABA has recently produced a film "You're in Control: Older Americans and the Law," designed for seniors. The 20-minute film illustrates how the law can be a powerful tool to assist seniors in resolving difficult programs. The commission has noted the emergence of a new phenomenon—private attorneys whose practice focuses primarily on service to the elderly. To encourage this trend, the commission has produced and widely distributed a new publication: "Doing Well by Doing Good: Providing Legal Services to the Elderly in a Paying Private Practice." The current president of the ABA, William Falsgraf, has made legal problems of the elderly a primary focus of his term and places particular emphasis on the importance of life planning and the use of advance directives to prepare for financial, health care, and treatment decisions. Accordingly, in July 1985, the ABA Commission on Legal Problems of the Elderly and the Older Women's League sponsored a symposium "Taking Charge of the End of Your Life," a forum on living wills and directives.

The private bar has also responded to the needs of elderly persons in new ways on the State and local level. Currently, there are 40 State and local bar association committees on the elderly. Their activities range from legislative advocacy on behalf of seniors and sponsoring pro bono legal services for elderly people to providing community legal education for seniors. Nearly 50 State and local projects utilize private attorneys to represent elderly clients on a reduced fee or pro bono basis. In over 29 States, handbooks for seniors have been produced either by State and area agencies on aging, legal services offices or bar committees, which detail seniors' legal rights. Since 1982, attorneys in over half the States have had an opportunity to attend continuing education seminars regarding issues affecting elderly people. The emergence of training options for attorneys which focus on financial planning for long-term care and advance directives are particularly noteworthy.

As recognized by the American Bar Association, private bar efforts alone fall far short in providing for the needs of older Americans for legal help. The ABA has consistently maintained that the most effective approach for providing adequate legal representation and advice to needy older persons is through the combined efforts of a continuing Legal Services Corporation, an effective Older Americans Act program, and the private bar. With increased emphasis on private bar involvement, and with the necessity of leveraging resources, the opportunity to design more comprehensive legal services programs for the elderly exists.

### 4. PROGRAMS

Reductions in Federal funding have already caused serious cutbacks of existing legal services programs. Over the past few years, the LSC has been operating on a budget of a little over $300 million a year—only enough to provide about $9 a year in legal services for each poor person. Even this trifling outlay, however, has come under attack by conservatives and by those worried about Federal deficits. The Reagan administration has been a harsh critic of the program and has tried to persuade Congress to dismantle the corporation. The passage of the Gramm-Rudman-Hollings measure makes the prospects of federally funded legal services for the poor even more dismal. While no significant infusion of funding can be expected in the near future, the one ray of hope is that Congress has thus far prevented Federal funding from being shut off.

It is a basic tenet in our society that those who live under the laws should also have an opportunity to use the law. Access to the legal system for all persons is basic to our democratic system of government and the fundamental purpose of the Legal Services Corporation Act. The federally funded legal services program represents a significant improvement in the system of dispensing justice in this country and has gone a long way to alleviate the harsh consequences of being poor and unable to afford legal services. If we are to continue to make progress in the goal of equal justice and access for all, the continued funding of legal services by the Federal Government and the strengthened efforts of the private bar will be necessary.

## Chapter 13

# CIVIL LIBERTIES

## OVERVIEW

Since ratification of the 5th and 14th amendments to the Constitution which protects persons from being deprived of life, liberty, or property "without due process of law" and prohibits the denial to any person of the equal protection of the law, respectively, this country has continuously expressed its commitment to the civil rights and liberties of its citizens. During the 1960's, significant civil rights legislation was enacted—primarily as an indication of renewed Federal legislative concern that, for various reasons, discrimination against certain segments of our society was taking place. Civil rights issues have recently gained attention once again, primarily as a result of charges of lack of enforcement of existing civil rights laws.

While the country's awareness of the need to eliminate discrimination based on age has been somewhat slower to develop, significant gains were made with enactment of the Age Discrimination in Employment Act of 1967 and the Age Discrimination Act of 1975. Congress recognized that older people, like minorities and women, were subject to discrimination and were also entitled to have civil rights protections. Civil rights legislation helps older persons to overcome discrimination they often face as a result of unfounded and outmoded stereotypes about aging. These stereotypes and myths have often acted to deprive older people the freedom to participate fully in society and to deny them the opportunity to reach their full potential.

This chapter reviews two legislative measures not addressed elsewhere in this volume which were introduced during the 99th Congress and which touch upon the liberties and rights of elderly and other persons. Although each of the bills had a different destiny, they deserve mention due to their impact or potential impact on the lives of the Nation's elderly.

The first of these measures is civil rights legislation introduced in Congress, in response to a Supreme Court decision, that many felt would turn the tide of the civil rights movement, including the movement toward expanded civil rights of the aged, in this country. While this civil rights legislation is still pending before Congress, hopes are high for its eventual passage. The second measure, amendments passed by Congress to permanently extend the Equal Access to Justice Act, which helps allow persons of modest means to defend against unjustified government action, was successfully passed and signed into law, after an earlier Presidential veto.

## A. CIVIL RIGHTS

The civil rights movement in the United States during the 1950's and 1960's resulted in a number of laws which dealt with discrimination and bias against disadvantaged groups in American society. In title VI of the Civil Rights Act of 1964, for example, Congress prohibited discrimination on the basis of race, color, or national origin in programs or activities receiving Federal financial assistance. In title VII of the Civil Rights Act, Congress made it unlawful for many private employers to discriminate on the basis of race, color, sex, religion, or national origin.

Against this background, Congress, in November 1975, enacted the Age Discrimination Act as part of the amendments to the Older Americans Act. The act prohibits discrimination on the basis of age in all programs and activities receiving Federal financial assistance and prohibits recipients from taking actions that result in denying, or limiting services, or otherwise discriminating on the basis of age. Congress also passed four new policies and programs between 1972 and 1976 designed to end what some believed to be pervasive sex discrimination in American education. One of these, title IX of the Education Amendments of 1972, was modeled after the Civil Rights Act of 1964, and prohibits discrimination on the basis of sex in most education programs and activities receiving Federal financial assistance.

Proponents of strong nondiscrimination laws have complained that coverage under title IX and other civil rights laws has been too limited and that enforcement of the laws has been inadequate. On the other hand, some people believe that the Federal Government has too broadly interpreted coverage provisions and has levied too heavy a hand in the way it has enforced the civil rights laws, including title IX. They feel that financial and administrative burdens have been imposed that far outweigh any benefits gained. Title IX has recently become part of a larger controversy as to whether the protections afforded by the civil rights laws have been effective and whether enforcement of those laws has been adequate.

Activity in the area of civil rights during 1984 was largely in response to the Supreme Court's February 1984 decision in *Grove City College* v. *Bell*, which centered on title IX of the Education Amendments of 1972. Many Members of Congress felt that the *Grove City* ruling severely narrowed the application of coverage of title IX, and they anticipated that, as a result of changed agency enforcement practices and subsequent judicial interpretations, other antidiscrimination statutes would be similarly narrowed. Indeed, as a result of the *Grove City* ruling, the Reagan administration immediately closed at least 23 civil rights investigations and narrowed the scope of 18 others. Legislation was introduced in 1984 to reaffirm the pre-*Grove City* judicial and executive branch interpretations and enforcement practices which provided for broad coverage of these antidiscrimination statutes. Hopes for passage of a civil rights bill in 1984 were scuttled at the end of the 98th Congress, but sponsors vowed to keep up the fight. Competing versions of civil rights legislation were introduced in 1985 in the 99th Congress.

## 1. Issues

Title IX of the Education Amendments of 1972 prohibits discrimination on the basis of sex in most education programs and activities receiving Federal financial assistance. The legislative history of title IX and of other antidiscrimination statutes dealing with race, national origin, handicap, and age, evidence a strong congressional intent to require broad coverage of the antidiscrimination provisions. Prior to 1981, Federal agencies charged with administering the distribution of Federal assistance and enforcement of the antidiscrimination statutes promulgated regulations which also spoke in terms of broad coverage. For example, the U.S. Department of Health, Education, and Welfare, and later the U.S. Department of Education, interpreted title IX broadly to mean that if any part of an institution received Federal funds, all parts of the institution were subject to the antidiscrimination statute. In addition, U.S. antidiscrimination statutes have a rich history of judicial interpretations which embrace broad coverage.

The U.S. Department of Justice originally concurred in this broad interpretation, but, in August 1983, after raising the issue in several other cases, it filed a brief with the U.S. Supreme Court in *Grove City College* v. *Bell*, in which it argued that title IX coverage should be restricted to the specific program that receives assistance, rather than the institution as a whole. Until that time, the Government had consistently argued that title IX coverage for the entire undergraduate institution operated by Grove City College was authorized by the statute.

The specific issues raised in the *Grove City* case were whether the receipt of Federal financial assistance by students [Pell grants and guaranteed student loans] was sufficient to subject the college to title IX and, if so, whether the entire institution would be subject to title IX or only a more narrowly defined part of the institution, such as its financial aid program.

On February 28, 1984, the Supreme Court ruled that the receipt of Federal financial assistance by students was sufficient to subject the college to title IX, but that it applies only to the financial aid program receiving the Federal aid and not to the entire institution. Thus, in deciding that title IX did not bar sex discrimination in the institution as a whole, but affected only those departments or programs that actually received Federal aid, the Supreme Court applied a very narrow reading of the law.

Supreme Court Justices Marshall and Brennan dissented from the majority Court's opinion, stating that when financial assistance is intended to serve as Federal aid for the entire institution, the institution as a whole should be covered by the statute's prohibitions on sex discrimination and that any other interpretation clearly disregards the intent of Congress and severely weakens the antidiscrimination provisions of title IX.

Civil rights, religious, and women's groups attacked the majority opinion, saying that it would narrow the scope not only of title IX, but also of similar Federal laws prohibiting discrimination on the basis of race, age or physical handicap. While the *Grove City* ruling interpreted only the Federal law against sex discrimination, nearly identical language is used in the statutes forbidding discrimination on the basis of race, national origin, age, and handicap. Like title IX, the 1964 Civil Rights Act, the 1973 Rehabilitation Act, and the Age Discrimination Act of 1975, prohibit discrimination in programs or activities receiving Federal financial assistance.

Of the four civil rights statutes thought to be affected by the *Grove City* decision, the Age Discrimination Act of 1975 is of particular importance to the elderly. As previously mentioned, the act prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. Specifically, the act prohibits recipients from taking actions that result in denying or limiting services, or otherwise discriminate on the basis of age. It should be noted, however, that the act contains certain exceptions that permit use of distinctions which may have a disproportionate effect on the basis of age. Notwithstanding these exceptions, the act applies to persons of all ages. Like other Federal financial assistance civil rights statutes, the act applies only to programs or activities in which there is an intermediary (recipient) standing between the Federal financial assistance and the ultimate beneficiary of that assistance. It does not, for example, apply to programs of direct Federal financial assistance, such as the Social Security Program.

### 2. LEGISLATION

Immediately after the Supreme Court's decision in *Grove City* was handed down, several bills were introduced in Congress to overturn it by making institutionwide coverage of title IX automatic. In 1984, the Civil Rights Act of 1984 was introduced in both the House and the Senate to restore title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, to their pre-*Grove City* vitality. The bill would have amended the coverage provisions of the four civil rights laws by making three major changes in the four current laws: (1) Deletion of "program or activity"; (2) addition of a definition of "recipient"; and (3) amendment of the enforcement section of each law so that there could be no question that the Federal funding cutoff weapon would be directed at the recipient," but that it would be limited to the particular assistance which supports the noncompliance.

In 1984, the House passed similar legislation by a vote of 375 to 32. In the Senate, however, the legislation encountered numerous difficulties and ultimately failed to obtain passage in the final days of the 98th Congress, when conservative opponents mounted a successful filibuster against it. Opponents of the bill contended that it was more than a mere reversal of the *Grove City* decision and that it would greatly expand Federal authority in this area. They asserted that assistance of any kind to any part of any public or private enterprise would trigger all of the civil rights regulations and enforcement procedures of the Federal agencies with respect to all other parts of the enterprise or institution, no matter how remote from the part receiving assistance. They also argued that it went beyond the *Grove City* ruling because it attempted to amend three additional laws, not even in issue in that case. The Reagan administration opposed the bill on the grounds that it would be an unwarranted interference with State prerogatives and that there would be a major increase in litigation, in the Federal regulatory burden, and in the costs of civil rights enforcement.

In the 99th Congress, rival bills were introduced which are designed to counteract the *Grove City* ruling, but which take very different approaches to the way in which they would amend title IX and the three other civil rights laws thought to be affected by the Supreme Court's decision. On January 24, 1985, H.R. 700, the Civil Rights Restoration Act of 1985, was introduced by Representative Augustus F. Hawkins. Later that day, S. 272, the Civil Rights Amendments of 1985, was introduced in the Senate by Majority Leader Robert Dole.

Sponsors of the Civil Rights Restoration Act of 1985 say that it would insure that laws barring bias on the grounds of race, sex, age, and handicap would apply to an entire institution if any part of it received Federal aid. In addition, it amends all four statutes in the same manner to make sure that all recipients of Federal funds, and not just schools, would be covered by antibias statutes. While it resembles, to a great extent, the predecessor legislation introduced in 1984, proponents of the legislation believe that the measure has addressed the problems raised in the 98th Congress. For example, it retains the "program or activity" language and attempts to state the scope of coverage by defining the terms in words that are simple and direct. It specifically provides that the term "program or activity" means "all of the operations" of any of the following, when a part receives Federal assistance: A State or local government department or agency; a State or local government entity that distributes such assistance (as well as such department or agency and each other entity to which the assistance is extended); a university or a system of higher education; a local educational agency or other school system; a corporation, partnership, or other private organization; or "any other entity determined in a manner consistent with the coverage provided with respect to entities described above." The bill also includes last year's amendment to the enforcement sections of the four statutes which is designed to insure that the pinpointed fund termination remedy is retained.

Critics of the bill insist that the bill still contains some ambiguities. They cite the continued use of the word "entity" which is not defined and raise questions as to how the measure might affect an ultimate beneficiary. They also challenge the provision of the bill dealing with corporations, claiming it would expand coverage from what it was prior to the Supreme Court ruling. Opponents argue that the bill's revised language for pinpoint termination would expand termination authority since, in their opinion, it can be broadly construed.

S. 272, introduced by Senator Dole, as a middle-ground proposal and which has the support of the administration, provides that for educational institutions receiving Federal financial assistance, the phrase "program or activity" would mean the institution itself. Thus, the bill extends the protection of civil rights laws only to an educational institution. The Dole bill also includes a clause to ensure that the *Grove City* case does not serve as precedent for judicial interpretation of civil rights coverage in other areas. Despite this clause, supporters of the Kennedy bill remain concerned that courts and officials could continue to interpret the law in a narrow way regarding noneducational institutions. They believe that restoration of a broad interpretation of program and activity must reach beyond education to forestall Federal funding of discrimination in such areas as health, transportation, social services, and economic development.

Congressional hearings on the pending civil rights legislation have been held. On May 21, 1985, the House Committee on Education and Labor reported out its version of H.R. 700. The reported version contained two amendments, which had been offered in committee by Represenatives Tauke and Jeffords, respectively, pertaining to abortion and the reach of the bill with regard to title IX coverage of religiously affiliated organizations. Neither provision, however, finds a counterpart in the May 22 reported version of the bill by the House Judiciary Committee. In the Senate, Senator Dole has promised prompt action on civil rights legislation, but prospects for the legislation are uncertain. Significant differences remain between the two versions of the bill, including substantial questions as to whether new obligations for those who receive Federal assistance will be created.

### 3. Prognosis

The *Grove City* ruling refueled interest about the status and direction of civil rights in this country. Generally, proponents of amending civil rights laws to ensure a broad interpretation of program or activity argue that narrow coverage would undermine the Federal Government's ability to enforce the laws vigorously and to effectively fight discrimination. Supporters of a more liberal and far-reaching bill have accused the Reagan administration of dragging its feet on antidiscrimination laws and of setting a tone that worked against civil rights advocates. Supporters of the narrow interpretation of program or activity in the civil rights laws emphasize that this approach is proper because it keeps Federal nondiscrimination requirements proportional to the benefits institutions and agencies receive from Federal aid. Extensive debate as to whether legislation would simply reestablish the scope of coverage to what it was prior to the *Grove City College* decision or whether it would expand or restrict it can be expected. A long legislative struggle lies ahead with regard to this legislation and its outcome will, in part, determine the future strength of the Nation's commitment to the civil rights of its citizens.

## B. EQUAL ACCESS TO JUSTICE

### 1. Background

The Equal Access to Justice Act (EAJA) provides that in judicial and administrative proceedings in which the United States is the losing party, Federal courts and Federal agencies shall, in certain circumstances, order the United States to pay the attorney's fees of the prevailing party. The EAJA was originally enacted in 1980 as title II of Public Law 96-481. It was widely viewed as making it possible for the ordinary, private citizen of modest means and the small business person to bring legal challenges to unjustified actions of the Federal Government. The act was amended in 1982 by section 292 of Public Law 97-248. A new amendment, passed by Congress in October 1984, was vetoed by the President in November of that year. The EAJA was subsequently amended and made permanent by Public Law 99-80 in August 1985.

## 2. ISSUES

In the United States, a court or agency may not ordinarily order one party to a proceeding to pay the attorney's fees of another. Hence a prevailing party is not entitled to collect attorney's fees from the loser and must usually bear this cost himself. This general rule, based on the common law, has numerous statutory exceptions, most of which Congress enacted in order to encourage private litigation to implement public policy in areas it thought desirable. The rule also has two major common law exceptions which derive from the historic authority of the courts to do equity in particular situations. In addition, the common law doctrine of sovereign immunity has prohibited suits and awards of attorneys' fees and other costs against the United States. Here too, however, there are numerous exceptions and about 40 statutes appear specifically to permit awards of attorneys' fees against the United States.

Proponents of fee shifting argue that to be made whole a person unjustly injured should not have to bear the expense of a lawyer. Others argue, however, that one has a right to sue or to defend himself without bearing the risk of having to pay the attorney's fees for both sides. Another line of argument involves questions of which method will more effectively further the public policy of encouraging meritorious claims and pursuing valid defenses. Without fee shifting, some plaintiffs with meritorious actions and some defendants with valid defenses fail to assert them because of the expense involved and because the amount at stake is not always worth an attorney's time.

During the 1970's, Congress began a series of hearings to examine the availability of awards of reasonable attorneys' fees and related expenses and the possible need to expand such awards to appropriate prevailing parties. These hearings focused on the limited liability of the United States for attorneys' fees. The hearings culminated in the enactment of the EAJA in 1980. The EAJA was enacted because Congress found that the expense involved may be deterring parties from seeking review of, and defending against, Government action that was not substantially justified.

The EAJA allows awards of attorneys' fees against the United States in two broad situations. The first, codified at 28 U.S.C. 2412(b), makes the United States liable to the same extent any other party would be liable under the common law and statutory exceptions, including those that do not specifically authorize fee awards against the United States. This provision contains no expiration date, nor are there any limitations on the assets or number of employees of parties eligible to recover fees, and no maximum hourly rate for fee awards. This provision was in the orignial EAJA and was not affected by either the 1982 or 1985 amendments, except for a technical change in the latter.

The second broad situation in which the EAJA authorizes awards of attorneys' fees against the United States is codified at 5 U.S.C. 504 and 28 U.S.C. 2412(d). These actions provide that, in specified agency determinations and in all civil actions (other than tort actions and tax cases) brought by or against the United States, the United States shall be liable for the attorneys' fees of prevailing parties unless it proves that its position was "substantially justified" or that "special circumstances" make an award unjust.

In order to be eligible for an award of attorneys' fees, a party must be: (1) An individual whose net worth does not exceed $2 million; (2) the sole owner of an unincorporated business or a partnership, corporation, association, or public or private organization (other than an agency) having a net worth not exceeding $7 million and no more than 500 employees; and (3) any charitable or other tax exempt organization regardless of net worth, unless it has more than 500 employees. The law sets a maximum for fee awards of $75 per hour unless the court or agency determines that a special factor justifies a higher fee. This portion of the EAJA was, by the terms of the original act, repealed effective October 1, 1984, but was reauthorized retroactively by Public Law 99-80.

According to a House report on the EAJA, during fiscal years 1982 and 1983, only 72 awards were granted, totaling less than $2.5 million. Of 192 applications filed for awards in administrative proceedings, only 8 resulted in awards—with the total amount awarded less than $36,000. At the court level, of the cases where fee applications were filed and closed in 1982, 64 resulted in awards, totaling $2,421,010. These awards were dramatically less than the $100 million annual cost estimated by the Congressional Budget Office in 1981 and higher amounts predicted by the Justice Department.

### 3. LEGISLATION

Because of the sunset provisions in the law, in 1985, Congress passed a set of amendments permanently extending the EAJA and making it retroactive to the date of the sunset. Besides extending the original provisions of the EAJA, the amendments somewhat further expand the liability of the United States for attorneys' fees and other expenses. It does so by making it clear that Federal courts and agencies may order the United States to pay attorneys' fees unless its position was substantially justified with respect to its conduct of the adjudication or litigation *and* the underlying action that led to the adjudication or litigation. This provision settled a split in the courts as to whether the position of the United States referred to the agency action which was the subject of the lawsuit or only the government's litigation position when determining substantial justification.

The bill also limits the determination of whether the position of the United States was substantially justified to the record made in the litigation or agency proceeding for which fees are sought so as not to permit additional discovery or evidentiary proceedings. The amendment was designed to respond to concerns raised by the President at the time he vetoed the 1984 amendments that the fee proceeding not become another trial and not involve matters not at issue in the principle litigation.

The amendments broaden the class of parties eligible for fee awards by raising the maximum assets a party may have and by including units of local government. It gives the courts a broader scope of review when a prevailing party appeals an agency fee determination. Finally, it authorizes fee awards against the United States in actions for judicial review of any action, not just of adversary adjudications. The amendments were signed into law by the President on August 5, 1985.

### 4. CONCLUSION

The EAJA expanded the liability of the United States for attorneys' fees and other expenses in certain administrative proceedings and civil actions. The primary purpose of the act was to ensure that certain individuals and other organizations would not be deterred from opposing unjustified governmental action because of the expense involved in securing the vindication of their rights. The act helped to reduce the disparity in resources between individuals, small businesses, and other organizations with limited means and the Federal Government.

Under the original EAJA, the number of eligible parties that have applied to recover fees has been low. In 1983, parties prevailed against the United States in an estimated 18,000 suits. During that year, however, only 108 parties applied for awards under the EAJA and 64 awards were made. The relatively low number of applications filed may be because attorneys do not have knowledge of the program. While the number of applicants is low, extension of the program will provide an incentive to the bringing of a meritorious claim against the Government or the undertaking of a justifiable defense even in the face of the great expense in pursuing litigation in this country.

# Chapter 14

# FEDERAL BUDGET

## OVERVIEW

Late in 1985, Congress took a significant step toward changing its handling of the Federal budget by enacting the Balanced Budget and Emergency Deficit Control Act of 1985, also known as "Gramm-Rudman-Hollings". Gramm-Rudman establishes a new budget process in an effort to force agreement on the difficult deficit-reducing decisions tying up the legislative process in recent years. Gramm-Rudman is a radical departure from the previous budget process in that it sets deficit targets and provides for specific automatic reductions to achieve these targets in the event other deficit-reducing legislation is not enacted first.

## A. BACKGROUND

### 1. The Budget Process

The Constitution divides the Federal Government's powers between the three branches of Government. Congress, the legislative body in this scheme, must originate all law-making. Congress may delegate to other bodies the power to formulate regulations, but these must conform to standards set by congressional legislation. One of the most important powers reserved to Congress is "the power of the purse"—the ability to tax and spend. Budgetary decisions ultimately rest with Congress, although the President has long had a substantial impact on taxing and spending decisions. In a 1921 budget act, Congress empowered the President to submit a budget proposal to the legislature, indicating his priorities and desires. This proposal has long formed the starting point for congressional debate on budgetary decisions, although it is not binding in any way.

The budget submitted by the President is comprehensive, however Congress makes its budgetary decisions in 13 separate general appropriations bills, each of which is the responsibility of one of the subcommittees of the House and Senate Appropriations Committees. Appropriations for a particular use must conform to specific authorizing legislation, enacted separately by Congress, before money can be appropriated to that use. Later in the process, Congress may provide further funding in the form of supplemental appropriations bills. When appropriations bills are not enacted before the start of the fiscal year, continuing appropriations bills are passed to allow governmental operations to continue.

### 2. ENTITLEMENTS

A significant amount of Federal Government spending now occurs in entitlement programs, such as Social Security, which do not require an annual appropriation. The rationale behind permanent appropriations entitlement is that Congress has created programs in which all who are entitled to benefits have a legally enforceable claim against the Government for those benefits, so Congress must pay out all amounts due unless and until changes in the law establishing and governing those programs occur.

Many feel that entitlement spending has gotten out of hand in recent years. The large amounts of spending involved in permanent appropriations creates a system in which Congress is unable to address the budget as a whole. Authorizing committees generally are unwilling to reduce spending in programs under their control. Without some overall agreement to make cuts in entitlement programs, individual committees could not be expected to independently reign in entitlement spending.

### 3. CONTINUING RESOLUTIONS AND BUDGET RECONCILIATION

The lack of budgetwide vision, coupled with the lack of discipline among authorizing committees, led to the passage of the Congressional Budget and Impoundment Act of 1974. This act implemented a reformed budget process built around two annual concurrent budget resolutions.

The act sets up a legislative timetable that focuses Congress' attention on the budget as a whole. The first of the concurrent budget resolutions, which sets out basic fiscal policies for taxing and spending to be pursued in the coming year, is to be adopted by both Chambers before May 15 of each year. Congress then uses this tool to guide it in actions on specific appropriations bills, tax bills, and bills creating or changing entitlement programs. All of these bills are supposed to be completed by early September, so that a second budget resolution may be enacted by September 15.

The second budget resolution allows Congress to reassess its particular actions in relation to the budget as a whole. If the aggregate numbers in this second resolution are inconsistent with the total new budget authority provided or with the amount of revenues projected for the coming year, the act allows for a process known as reconciliation. Reconciliation bills are designed to bring total spending and revenues in line with the second budget resolution by the start of the new fiscal year on October 1.

## B. ISSUES

In recent years, Congress has become increasingly paralyzed within its budget process. Efforts to control the deficit in the context of appropriations bills have caused numerous delays in passage, and further differences complicated the ability to produce conference reports. Congress has resorted to a series of continuing resolutions to permit agencies and departments to continue to pay salaries and operate programs until their regular appropriations become law. Reconciliation bills have been delayed further and further each year, to the point where no reconciliation was passed for fiscal 1986, which began in October of 1985.

The Federal deficit has increased at what many consider to be an alarming rate. The total national debt recently reached the $2 trillion mark. Alarmed at the potentially harmful economic effects of spiraling debt, and spurred by constituent pressure to control the deficit, Congress has seriously considered measures to enforce discipline in the budget process and limit congressional discretion. Measures proposed have included a constitutional amendment that would require Congress to report a balanced budget each year and legislation to provide the President with authority to veto individual line items in appropriations bills.

## C. LEGISLATION

The need to raise the debt ceiling above $2 trillion last fall triggered a response in the Senate. In late September, Senators Phil Gramm, Warren Rudman, and Ernest Hollings offered an amendment to the debt ceiling bill to reform the budget process by forcing the Congress to achieve specific deficit reductions targets each year to eliminate deficits by 1991. Early versions of the bill received considerable bipartisan interest from both Houses as well as from the White House. Many Members feared the political and economic consequences of increasing deficit spending, yet were unwilling to set automatic reductions in motion.

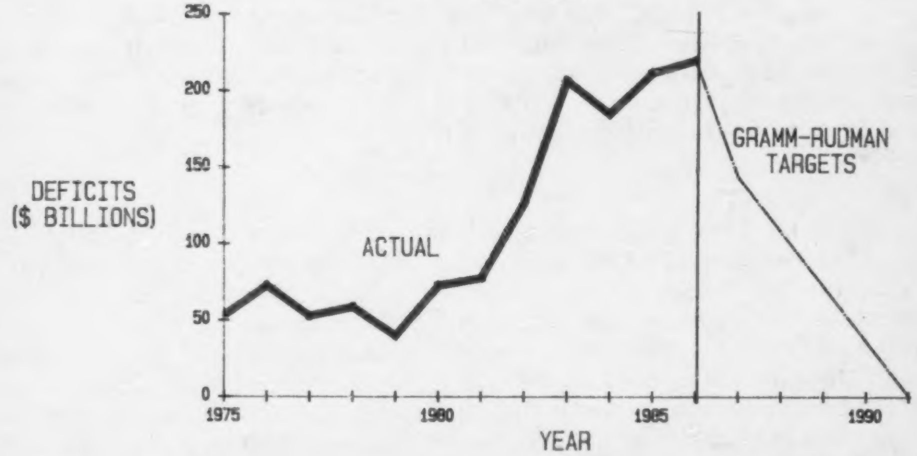
Gramm-Rudman has a unique history in that it was not brought about through the usual committee channels. The debt-ceiling increase had first passed the House of Representatives on August 1. The Senate then added the budget balancing plan to the debt ceiling measure, and passed the package on October 10. The House went immediately into conference on the original debt ceiling measure alone, and the conferees disbanded in disagreement on October 31. The following day, the House voted for the revision worked out by the conferees, but the Senate again voted for its original plan, with few modifications, on November 6. A second conference devised the final version of the bill in a series of private meetings with House and Senate leadership. On December 11, 1985, Congress passed Gramm-Rudman, and President Reagan signed the bill into law the next day.

### 1. Deficit Reduction Targets and Sequestration

Gramm-Rudman provides for annual reductions in the budget deficit which was projected to reach $220.5 billion in fiscal 1986. In moving toward the goal of $0 deficit by fiscal year 1991, it specifies deficit limits for each intervening year. In any year in which deficit limits are exceeded, the excess amount is to be automatically cut from the budget under a process known as sequestration. The act requires a $171.9 billion deficit cap for the current fiscal year—1986. The current estimate for the 1986 deficit is $220.5 billion, much higher than the maximum allowed, but the act limits the amount of sequestration to $11.7 billion for this first year of its operation. Current projections indicate an additional $40 to $60 billion in deficit reduction will be required in the 1987 budget by October 15 of this year to prevent automatic cuts from being triggered. The deficit cap for 1987 is set at $144 billion.

CHART 14-1

FEDERAL DEFICITS UNDER GRAMM-RUDMAN
1975-1990



Source: Office of Management and Budget, Historical Tables: Budget of the U.S. Government, Fiscal 1987, p. 1.1(2); and P.L.99-177.

Gramm-Rudman does not list specified cuts to be made in particular programs, but calls for arbitrary, across-the-board reductions in all programs not specially protected. Only when Congress and the President do not pas a budget within the target limit will automatic spending cuts be set in motion. The excess deficit would be divided in half, one-half of the cut is taken from the defense budget and the other half from domestic programs. The act sets up a procedure for calculating the resulting cuts in each program.

In fiscal 1986, $5.85 billion dollars is to be taken from the defense budget, wiht an equal amount to be deducted from nondefense programs. The funds cut from each program must be taken from unobligated sources. Obligated funds cannot be cut because this would put the Government in a position of breaching numerous contracts and commitments.

### 2. Budget Timetable

Gramm-Rudman has introduced substantial changes in both the mechanics and the theory of the budget process. The timetable for action has been compressed and considerably altered. Beginning with fiscal year 1987, the process is scheduled to work in the following manner.

The President submits his proposed budget to Congress early in the calendar year, with congressional committees to begin working on their own proposals shortly thereafter. A congressional budget resolution, the only one provided for under the act, will be passed by April 15, with reconciliation legislation completed by June 15.

House action on all annual appropriations bills, which by law originate in the House, must be completed by June 30. Then, the many new procedures introduced by Gramm-Rudman begin to come into play.

Using projections based on appropriations bills and other laws in effect at the time, the Director of the Office of Management and Budget (OMB) and the Director of the Congressional Budget Office (CBO) must issue a joint report on August 20. This report estimates budget base levels, determining whether a deficit over the target limit will result from Congress's budget plans. If the deficit is projected to exceed the target level for that year, the report must also contain specific dollar figures as to how much money will be sequestered from the accounts of the various governmental agencies and departments in order to meet the target.

The OMB/CBO report is presented to the Comptroller General of the United States, the chief officer of the General Accounting Office (GAO). The Comptroller General then has 5 days in which to resolve differences between the OMB and CBO projections, and make his own report to the President and Congress as to the necessity for any sequestration. Based on this report, the President must issue a sequestration order on September 1, if sequestration is required.

At this point in the budget process, the focus returns to Congress. Throughout September, Congress still has the opportunity to come up with an alternative to the sequestration by passing a budget which meets the deficit targets. If it fails to do so, the Presidential order takes effect as of October 1, the start of the fiscal year, and funds are to be withheld as of that date. On October 5, a revised OMB/CBO report is to be issued which takes account of any legislative actions (such as tax bills or apropriations bills) which were taken after the first report was issued. GAO follows with its revision 5 days later. On October 15, this final sequestration order issued by the President and based on the revised estimates, takes effect and sequestered funds are permanently canceled.

## 3. CONSTITUTIONALITY

Although fiscal 1986 sequestration takes effect on March 1, the process faces an uncertain future. On February 7, 1986, a Federal District Court found Gramm-Rudman unconstitutional on the grounds that it vests executive power on the Comptroller General. Since the Comptroller General is an official who is removable by Congress, the court reasoned that his actions are legislative in nature, and that the sequestration scheme violated the constitutional doctrine of separation of powers. The President's sequestration order will remain in effect, pending appeal to the Supreme Court. A Supreme Court order upholding the lower decision would overturn that order, and sequestered funds would be freed. If this occurs, under the fallback plan in the legislation, Congress would have to pass a joint resolution to reinstate fiscal 1986 sequestration and additional joint resolutions would be required to initiate sequestrations in later years. A Supreme Court ruling on Gramm-Rudman should be issued by July 1986.

### 4. Effect of Gramm-Rudman on the Elderly

Not all programs affecting senior citizens would be affected by the automatic cuts when budget targets are not met. The benefits paid under Social Security, railroad retirement tier I, Medicaid, foodstamps, SSI, and veterans pensions are fully protected from automatic cuts. However, the administrative costs of these programs are subject to automatic cuts, and there is a danger that the quality of service to the public could deteriorate.

On the other hand, the Federal civil service and military retirement programs, railroad retirement tier II and black lung disability, are subject to reductions up to the full amount of the annual cost-of-living adjustments (COLA's). As directed by Gramm-Rudman, the 3.1 percent COLA's scheduled to go into effect January 1, 1986, have been canceled.

Most health care programs including Medicare, veterans' health care, and community health centers would be subject to cuts in excess of inflation, but not more than 1 percent in fiscal year 1986 and not more than 2 percent in subsequent fiscal years.

Most other domestic programs, however, would be subject to unlimited across-the-board reductions based on a uniform percentage of current spending. When exempted and specially treated programs are removed from nondefense spending, approximately one-sixth of total outlays remains. The programs in this small portion of the budget will experience substantial reductions if the deficit targets are exceeded.

Under Gramm-Rudman the first sequestration of $11.7 billion takes place on March 1, 1986, for the fiscal year 1986 budget already in progress. This will produce a uniform reduction in nonexempt domestic programs of 4.3 percent, a total of $4.9 billion. Much higher percentage rate reductions are forecast for fiscal year 1987 and later years if automatic cuts go into effect. Many of these programs provide important services to senior citizens, such as housing, low-income energy assistance, older Americans programs, social services, transportation, health research into Alzheimer's and other diseases, block grants, and home weatherization projects. The potential for even more substantial cuts in these areas in the future has raised concerns.

## D. PROGNOSIS

Gramm-Rudman profoundly changes the Federal budget process. Budget projection figures and economic predictions beyond fiscal year 1986 offer no clue as to how Congress will move within the new framework. Automatic cuts take effect March 1 for fiscal year 1986. After that, automatic cuts would only occur when budget targets have not been met. The President's fiscal year 1987 budget, presented to Congress on February 5, offers one plan for meeting the $144 billion deficit target for fiscal 1987. This budget contains many proposals which have been consistently rejected by Congress in the past, but the looming threat of further automatic cuts may make some administration proposals more palatable to the Congress. Uncertainty about the constitutionality of the act, and the possibility of alternative deficit-reducing measures such as tax increases will also play a role in shaping congressional action in the coming months.

One of the purposes of Gramm-Rudman is to force Congress to enact legislation in advance of sequestration which meets the deficit targets. Budgets which do fulfill this requirement in fiscal years 1987 and beyond are certain to contain some cuts in programs for senior citizens, the character of those cuts is impossible to predict at this time. Programs exempt or specially treated in the sequestration process are not protected from change as part of congressional legislation, they are only guaranteed safe from the automatic sequestration designed to be the last resort.

# SUPPLEMENTAL MATERIAL

## Supplement 1

## 1985 HEARINGS HELD BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

### UNNECESSARY SURGERY: DOUBLE JEOPARDY FOR OLDER AMERICANS, WASHINGTON, D.C., MARCH 14, 1985, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

#### WITNESSES

H. Larry Penberthy, Seattle, Washington
Mary Margaret Armstrong, Evergreen Park, Illinois
Wallace Law, Pinehurst, North Carolina
Thomas B. Graboys, M.D., Director, Clinical Services, Harvard University Medical School, Boston, Massachusetts
Eugene G. McCarthy, M.D., Director, Health Benefits Research Center, N.Y. Hospital/Cornell University, New York, New York
Norman P. Harberger, Vice President, Administration, Rohm and Haas Company, Philadelphia, Pennsylvania
William Sheehan, Vice President, Personnel, Dana Corporation, Toledo, Ohio
Vita Ostrander, President, American Association of Retired Persons, Washington, D.C.
Richard P. Kusserow, Inspector General, Department of Health and Human Services, Washington, D.C.
James L. Scott, Acting Deputy Administrator, Health Care Financing Administration, Washington, D.C.

#### ISSUES RAISED AND TESTIMONY SUMMARY

On March 14, 1985, the Special Committee on Aging convened a hearing to examine the extent of inappropriate utilization of surgical procedures commonly performed on Medicare and Medicaid beneficiaries. Studies show that older Americans are disproportionately harmed by unnecessary surgery. Individuals over 65 undergo 80 percent more surgery than those under 65 years of age and the risk of complications, disability, and death from surgery and general anesthesia increases steadily with age.

The first attempt by the Congress to identify and deal with the problem of unnecessary surgery in the Medicare and Medicaid programs was launched by the House Interstate and Foreign Commerce Subcommittee in 1975, which concluded that approximately 2 million unnecessary surgical procedures had been performed in

1974 at a cost of $4 billion. In 1978, the Federal Government initiated two demonstration experiments which studied the effects of voluntary second surgical opinions in New York and Detroit and a trial program which encouraged the public through media promotion to obtain second surgical opinions and offered a nationwide toll-free hotline information service to consumers. The most important finding to come out of the demonstration programs was that voluntary SSOP does not work (only 3 percent of Medicare beneficiaries participated) and therefore is not cost effective. However, a seven year study by the Health Care Finance Administration shows that the mandatory SSOP in the Massachusetts Medicaid Program reduced elective surgery rates by as much as 30 percent.

Testimony before the Senate Aging Committee by Richard P. Kusserow, Inspector General of the Department of Health and Human Services, representatives of private sector firms and national health insurance carriers state that mandatory second surgical opinions are a cost effective means to reduce the amount of unnecessary surgery received by Medicare beneficiaries and, in turn, dramatically reduce Medicare expenditures.

## RURAL HEALTH CARE IN OKLAHOMA, OKLAHOMA CITY, OKLAHOMA, APRIL 9, 1985, HON. DON NICKLES, PRESIDING

### WITNESSES

Lewis Farmer, Administrator, Wetumka General Hospital, Wetumka, Oklahoma
Ron Webb, Administrator, Holdenville General Hospital, Holdenville, Oklahoma
John Nienhuser, Administrator, Tahlequah City Hospital, Tahlequah, Oklahoma
John Neal, Administrator, Pawnee Municipal Hospital, Pawnee, Oklahoma
Jerry Hulin, Executive Vice President, Innovation Health Programs, Oklahoma City, Oklahoma
Greg Guntly, President, Saint Joseph Regional Center, Ponca City, Oklahoma
Jonathan C. Ihrig, Chairman, Health Committee, Blackwell Chamber of Commerce, Blackwell, Oklahoma
Orla Flaker, Senior Citizen Advocate, Blackwell, Oklahoma
Dr. Wallace Byrd, Senior Citizen Advocate, Coalgate, Oklahoma
Stephen Peter, Executive Director, Oklahoma Health Planning Commission, Oklahoma City, Oklahoma

### ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of this hearing was to illustrate how disparity between urban and rural hospital reimbursement under Medicare's Prospective Payment System [PPS] is exacerbating already existing problems for rural hospitals.

The problems which threatens the availability of rural health care will directly impact elderly Oklahomans who reside in rural areas. Already, many are driving into areas zoned "urban" for physician care so that they won't have to bear as high of cost in making up the difference in what the government pays doctors in rural areas. Rural elderly face the possibility of losing their community hospitals; many fear that they won't even be able to get emergency care when it is needed.

Rural hospitals located in economically depressed and high unemployment areas are operating with dramatically decreased occupancy rates and reimbursement losses. They are operating at a deficit and are forced to lay off employees which further compounds the unemployment problem in these areas where the local economy depends heavily on the hospitals as a major source of employment. Some must close or cut back on services by converting many of the vacant beds into swing beds or consolidating services with other similar hospitals. Under such circumstances, these hospitals are having difficulty in recruiting skilled physicians because reimbursement for rural physicians tends to be lower than those in the urban areas. Furthermore, since these hospitals are operating at a deficit, they do not have the resources available to invest in capital equipment which serves as a further disincentive to recruiting young, quality physicians who are not anxious to work with older and out-dated facilities.

Economically, consolidation or the closing of hospitals would serve as a deterrent to physicians locating in these rural areas and in turn a deterrent to other people considering settling there. There is grave concern among members of many rural communities that as hospitals close or consolidate services, and the physicians who are presently located in these communities grow closer to retirement, they will not be replaced and their communities will be left with sub-standard health care.

## PROSPECTS FOR BETTER HEALTH FOR OLDER WOMEN, TOLEDO, OHIO, APRIL 15, 1985, HON. JOHN GLENN, RANKING MEMBER, PRESIDING

### WITNESSES

Mrs. Billie Sewell Johnson, director, Area Agency on Aging, Toledo, Ohio.

Eileen Metress, Ph.D., Associate Professor of Education, University of Toledo, Toledo, Ohio.

Ethel Mercer, yoga instructor, Toledo, Ohio.

Dr. John F. McGreevey, Jr., director, Office of Geriatrics, Medical College of Ohio, Toledo, Ohio.

Robert A. Harootyan, senior analyst, Office of Technology Assessment, Washington, D.C.

Dr. Raymond W. Gifford, chairman, Department of Hypertension and Nephrology, Cleveland Clinic, Cleveland, Ohio.

Deanne Damschroder, patient services coordinator, Northwest Ohio Chapter of The Arthritis Foundation, Toledo, Ohio.

### ISSUES RAISED AND TESTIMONY SUMMARY

Senator John Glenn, Senior Democratic Member of the Committee, chaired this hearing in Toledo, OH, on April 15, 1985, to explore the prospects for better health for older women. The hearing was the second in a series of hearings, chaired by Glenn, on "Women in Our Aging Society." Assisting Senator Glenn on the panel was Rep. Marcy Kaptur from Toldeo, and Martin Janis, former director of the Ohio Commission on Aging.

Senator Glenn said that health care is of special importance to women because they live longer than men, and because they suffer from more chronic illnesses and more days of disability than men. The hearing explored the prospects for improving the health status of older women through health promotion activities, progress in "coping" technologies, and advances in biomedical research. Senator Glenn stressed the need for more research in the fields of geriatrics and gerontology and the importance of self-help measures to a longer and healthier life.

Witnesses at the hearing, attended by nearly 1,000 older men and women, discussed how women of all ages can improve their later years through health promotion and disease prevention today. Experts also discussed the impact of new technology on the diagnosis and treatment of disease.

## PACEMAKERS REVISITED: A SAGA OF BENIGN NEGLECT, WASHINGTON D.C., MAY 10, 1985 HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Carolyne K. Davis, Ph.D., Administrator, Health Care Financing Administration, Washington, D.C.
Frank Young, M.D., Commissioner, Food and Drug Administration, Washington, D.C.
Wanda L. DeHart, Millersville, Pennsylvania
Howard Bliss, Ojai, California
Jacqueline Fischer, Indian Harbour Beach, Florida
Brendan P. Phibbs, M.D., Pacemaker Quality Control Expert, Jackson, Wyoming
William Stollhans, Assistant Chief, White Collar Crime Division—FBI, Washington, D.C.
Michael Zimmerman, Associate Director, Human Resources Division—GAO, Washington, D.C.
James Casey, Supervisory Investigator, Miami Resident Post—FDA, Miami, Florida
Victor Spanioli, Investigator, Miami Resident Post—FDA, Miami, Florida
Norman Weldon, Ph.D., President, Cordis Corporation, Miami, Florida

### ISSUES RAISED AND TESTIMONY SUMMARY

Many of the problems identified in the Senate Aging Committee's September 1982 hearing on Fraud, Waste and Abuse in the Medicare Pacemaker Industry, are still as urgent in 1985. Of particular concern are the continuation of fraud and abuse in the pacemaker industry, unnecessary new pacemaker implants and replacement surgeries, and the sluggish response of the Health Care Financing Administration's [HCFA] and the Food and Drug Administration [FDA] to Congressional mandates.

Recent information indicates that as many as 1 out of 3 new pacemaker implants and 2 out of 3 pacemaker replacements may be unnecessary. This unnecessary surgery results in part from physicians' poor understanding of electrocardiography and cardiac arythmias—skills required to make judgments of the need for pacemaker insertions. Furthermore, there are some financial incentives which may encourage some unscrupulous physicians and hospitals to be overly eager to diagnose the need for replacement of a pacemaker, often with a more sophisticated and expensive model than is needed.

Under the new DRG system, Medicare provides incentives for hospitals to "double dip" from both Medicare and a pacemaker manufacturer, by collecting a warranty credit from the manufacturer for a pacemaker that is explanted and returned, and then also collecting a full DRG payment for the replacement surgery, which includes the price of the replacement pacemaker. In the hearing, HCFA Administrator, Carolyne Davis, Ph.D., stated that HCFA would need new authority to recover Medicare funds for pacemakers removed during the term of an applicable warranty.

In only 26 percent of replacement surgeries were the Peer Review Organizations (PROs) successful in obtaining all of the warranty information necessary for Medicare to recover monies under manufacturers warranties. Despite their federal contract requirement for 100 percent review, PROs are reviewing fewer than half of pacemaker implants, and are declaring a scant 5.1 percent of these surgeries to be unnecessary. In March 1985, HCFA instructed all PROs that they should cease gathering information on pacemaker warranties and replacement pacer leads, claiming that the FDA now maintains a Registry including such information. Minutes of meetings between HCFA and FDA personnel, obtained by the Committee, indicate that the Registry is far from complete and that high level personnel were aware of this fact at the time they discontinued PRO data collection efforts.

Witnesses from the General Accounting Office testified that the pacemaker DRGs may be inflated because HCFA based the DRG payments on unaudited cost reports, which tend to overstate actual costs, and because pacemaker surgery is much less time consuming and difficult than it was when the payment rates were calculated originally.

Witnesses from the Federal Bureau of Investigation (FBI) and the Food and Drug Administration (FDA), presented facts from investigations and criminal prosecutions of pacemaker manufacturers, which indicated problems of quality control and illegal sales schemes are still jeopardizing beneficiaries and the Medicare program.

## THE PENSION GAMBLE: WHO WINS? WHO LOSES?, WASHINGTON, D.C., JUNE 14, 1985, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Ronald L. Sprague, P.E., Evendale, Ohio
Madeline S., Astoria, New York
Lola Falls, Vancouver, Washington
Margery Boley, Columbus, Ohio
Dallas Salisbury, President, Employee Benefit Research Institute, Washington, D.C.

Judy Schub, Legislative Representative, American Association of Retired Persons, Washington, D.C.

Harry Smith, Manager, Special Projects, Sun Company, Radnor, Pennsylvania

Alan Reuther, Associate General Counsel, International Union, United Automobile Workers, Washington, D.C.

John Sheehan, Legislative Director, United Steelworkers of America, Washington, D.C.

## ISSUES RAISED AND TESTIMONY SUMMARY

This hearing examined the remaining problems in the delivery of retirement pension benefits more than a decade after the passage of the Employee Retirement Income Security Act (ERISA). Many workers who fail to receive pensions do so for one of four reasons: 1) they are not covered by a pension on their job, 2) they are covered but fail to stay with the employer long enough to vest in a benefit, or 3) they vest in the pension, but leave the employer and spend a lump-sum distribution, or 4) have their benefits reduced or eliminated through integration with Social Security.

The first panel of witnesses at the hearing described the circumstances that have caused them not to receive pension benefits even though they worked for employers with pension plans. Madeline S. worked for 23 years for a New York bank, but was excluded from the bank's pension plan as part of a group of hourly employees. Lola Falls worked for a trucking company in the State of Washington for 9½ years and was fired two months before she vested in her pension benefits. Marge Boley retired from a large retail chain after 20 years to find that her pension benefits were reduced to nothing through integration with Social Security. Ronald Sprague, a professional engineer in his mid-40s, had worked for 5 employers over a period of 22 years, and, as yet, had earned no pension benefits.

Mr. Salisbury discussed the reasons for lack of pension coverage. Pensions are provided voluntarily by private employers. Small employers, in particular, are unlikely to provide pension plans for their employees for a variety of reasons, not the least of which are the costs, and in some cases, the administrative complexity of doing so. Just over half, fifty-two percent of workers were covered by private pensions in 1983. Pension coverage tends to be highest in the manufacturing sector and lowest in the service sector, and among small business and non-union employers. Low paid and part time workers are particularly disadvantaged.

Other witnesses discussed the extent to which some of these problems affect pension benefits. Under present law, employees must generally stay at a job 10 years before vesting in the benefits they are accruing. In 1981, the average job tenure for men at ages 40–44 was 8 years. It was even shorter for younger workers. In addition to the possibility that the worker will not vest in a pension plan, the formula used to determine pension benefits may reduce pension benefits for workers who change employers. Often benefits that might be paid in retirement are spent when workers change employers and receive an early distribution of their retirement money. In addition, that pension benefit may be substantially reduced—or even eliminated—by integrating with Social Security benefits.

Witnesses from business and labor discussed the changing nature of the workforce and the changes in pension needs and designs to respond.

### AMERICANS AT RISK: THE CASE OF THE MEDICALLY UNINSURED, WASHINGTON, D.C., JUNE 27, 1985, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

#### WITNESSES

Margaret DiLombard, Jackson, Michigan
Beulah Shuffler, San Francisco, California
Elizabeth Morrison, Vice President, Herget and Company, Inc., Baltimore, Maryland
Gordon Schiff, M.D., Cook County Hosital, Chicago, Illinois
Henry Manning, President, Cuyahoga County Hospital System, Cleveland, Ohio
Patricia Butler, J.D., Health Policy Consultant, Boulder, Colorado
Uwe Reinhardt, Ph.D., Professor, Princeton University, Princeton, New Jersey

#### ISSUES RAISED AND TESTIMONY SUMMARY

There are 35 million Americans who find themselves without health insurance. 5.5 million of these are age 45 to 54 and 2.9 million are age 55 to 64. Surprisingly, even 389,000 persons over the age of 65 are without insurance of any kind even though the common perception is that the elderly are taken care of by Medicare and Medicaid. The medically uninsured breaks down into five broad categories: 1.) The unemployed and their families who do not qualify for Medicaid or other categorical health insurance programs who can not afford health insurance, and who could not afford to pay for the costs of health care should the need arise. 2.) Part-time workers whose employer does not offer a plan or who can not afford to participate in a plan. 3.) Full time workers who are uninsured because they can not afford to participate in employer plans, or whose employer does not offer a plan, or who elects not to participate in a plan. 4.) Poor persons who can not afford private or employee sponsored health insurance and who are not eligible for categorical programs. 5.) Persons who are not low income but who can not afford health insurance. In addition to these, two other categories of the uninsured are increasing in prevalence. They are widowed or divorced persons and their families whose change in marital status causes them to lose their insurance and persons who, because of some pre-existing illness or impairment, are considered by insurers to be too risky to insure.

While the need for health insurance has been growing, the traditional sources of government-sponsored health coverage—primarily Medicaid and other categorical programs—have been shrinking. Currently, only 46 percent of all Americans living in poverty, or near poverty, qualify for Medicaid. For the uninsured in need of health care there are few alternatives available. Most end up at the doors of community health clinics funded by public funds or private charities or they turn to hospital emergency rooms. Private hospitals, in an effort to reduce their uncompensated care caseloads, have been known to "dump" seriously ill uninsured patients on publically-funded hospitals which are obligated to maintain open door policies. This is causing serious financial problems for those hospitals who are committed to serving a large volume of Medicare, Medicaid and uninsured populations.

At the Federal level, several options have been suggested to help ease the impact of this problem for both uninsured persons and the providers of health care for the uninsured. One of many proposals is that there be included under Medicare's Prospective Payment System a disproportionate share adjustment in the payments made to hospitals that provide large portions of free care. This proposal has substantial support both within and outside of Congress; the major roadblock has been the Health Care Financing Administration. Another suggestion is that all health insurance must provide that insured persons may continue such policies for a specified time, or even indefinitely, if they pay the full premiums themselves. A third possibility is mandating that private employers offer an option of continued health insurance to employees who are laid off or the spouses of employees who have a change in family status (ie. divorce or death of the primarily insured spouse).

## THE GRAYING OF NATIONS II, NEW YORK, NEW YORK, JULY 12, 1985, HON. JOHN GLENN, RANKING MINORITY MEMBER, PRESIDING

### WITNESSES

Dr. Robert N. Butler, chairman, Department of Geriatric and Adult Development, Mount Sinai School of Medicine
Dr. Alvar Svanborg—Sweden
Dr. John Grimley Evans—United Kingdom
Dr. Francoise Forette—France
Dr. Carel Hollander—The Netherlands
Dr. David Macfadyen—World Health Organization
Professor Nana Apt—Ghana
Dr. Ma Haide—People's Republic of China
Dr. Jorge Litvak—Pan American Health Organization
Ms. Julia T. de Alvarez—Dominican Republic
Dr. Edit Beregi—Hungary
Dr. Dmitri Chebotarev—Soviet Union
Dr. Kazutomo Imahori—Japan
Dr. T. Franklin Williams, Director, National Institute on Aging, Washington, DC

### ISSUES RAISED AND TESTIMONY SUMMARY

This hearing, chaired by Senator Glenn, was a follow-up to the Committee's 1977 hearing, "The Graying of Nations: Implications," and was held when leading gerontologists from around the world were in New York City to participate in the XIIIth International Congress of Gerontology. The purpose of this hearing was to bring together leaders from both industrialized and developing countries to examine the global challenges of increased life expectancy, with the goal of a more vigorous and secure old age in the future.

Recent statistics from the United States Census Bureau show that the percentage of older people in every nation is increasing, with the largest increase occurring in the less developed countries.

Twelve leading gerontologists from around the world testified on what their countries are doing to adapt to the demographic changes taking place due to the increase in life expectancy. In particular, the witnesses discussed the health and social services that are provided to the elderly in their homes and communities, the need for increased training of health professionals in geriatrics and gerontology, and they explored opportunities for collaborative research on aging among nations.

### THE CLOSING OF SOCIAL SECURITY FIELD OFFICES, PITTSBURGH, PENNSYLVANIA, SEPTEMBER 9, 1985, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

#### WITNESSES

Sister Helen Elizabeth McElwain, Pittsburgh, Pennsylvania
Byrd Brwon, Esquire, Pittsburgh, Pennsylvania
Charles Harris, Pittsburgh, Pennsylvania
Herbert Doggette, Deputy Commissioner for Operations, Social Security Administration, Baltimore, Maryland
Rose Lepore, Regional Commissioner, Social Security Administration, Philadelphia, Pennsylvania
Kris Kramer, President, Local 3231, American Federation of Government Employees, Ambridge, Pennsylvania
Jill Hastings, Vice President, Local 3231, American Federation of Government Employees, Ambridge, Pennsylvania

#### ISSUES RAISED AND TESTIMONY SUMMARY

Despite the fact that the Social Security Administration runs the most efficient administrative services of any private or public insurance program, SSA plans to cut back staff by up to 20 percent over the next five years in the name of cost efficiency. Sixteen field offices were closed or consolidated this year, with 770 others targeted for review and possible closing by the end of 1987. The concern is that the quality of public service will suffer because of the efforts for cost efficiency.

SSA has developed a new methodology for services delivery reviews for upgrading, downgrading, or closing of field offices on a more uniform national basis. The procedures were designed to establish a clear, consistent, and comprehensive framework for evaluating the effectiveness of SSA field facilities. Mr. Doggett claims that computerization will enable claims to be processed more quickly and accurately, and thus allow for consolidation of SSA offices. Doggett contends that it will not really affect service to beneficiaries because 80 to 90 percent of the services provided by a field office can be handled over the telephone. However, in an informal survey of the SSA phone operation conducted by the Aging Committee staff, 50 percent of the numbers called at the beginning of the month were busy and took an average of 4.4 calls to complete, 75 percent of the completed calls at the beginning of the month—this is 2 weeks at the beginning of the month—were put on hold with an average wait of 4.5 minutes; 40 percent of the questions asked received either wrong or misleading answers.

Sister Helen explained how difficult it is for severly disabled and elderly beneficiaries to travel even a couple of miles to an SSA District office. Representatives of AFGE/Social Security Administration expanded upon this point, explaining that handling SSA beneficiaries is a highly personalized service frequently requiring extensive interviews with individuals to detemine exactly what the problem is and describing procedures. This type of service should be readily accessible in areas with high concentrations of elderly and disabled. Furthermore, when assigned to provide this type of service, evaluating an office merely in terms of the number of claims they handle a week is an inaccurate measure of the workload.

## MEDICARE DRG'S: CHALLENGES FOR QUALITY CARE, WASHINGTON, D.C., SEPTEMBER 26 1985, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

### WITNESSES

Mrs. Carol Mahla, Minnesota
Mrs. Margaret Buttrill, Virginia
Mrs. Betty Kratt, California
Karl Kellawan, M.D., California
James Hunter, M.D., Chairman, A Hospital Utilization Review Committee, North Carolina
Edward McKenzie, M.D., General Surgeon, North Carolina, Barbara Jones, R.N., A County Home Health Care Coordinator, North Carolina S.R. Greenberg, M.D. Internist, Pennsylvania
David Brodsky, Ph.D., Professor, University of Tennessee at Chattanooga, Chattanooga, Tennessee
Thomas Dehn, M.D., President, American Medical Peer Review Association, Milwaukee, Wisconsin (accompanied by Robert Sherrill, M.D., Kenneth A. Platt, M.D. and Frederick Crisafulli, M.D.)

### ISSUES RAISED AND TESTIMONY SUMMARY

According to a six month investigation conducted by the Aging Committee into the implementation of Medicare's Prospective Payment System [PPS] there have been serious implications for Medicare patients as some hospitals try to contain costs by releasing patients inappropriately or prematurely. This, the first in a series of three hearings, looked into the problem from the physician and hospital perspective.

One physician testified that he felt pressured by hospital administration to release patients when the average length of stay for a patient's DRG elapsed, even if he felt the patient was still in need of acute care. Barbara Jones, a county home health nurse, gave testimony confirming pressure is placed on physicians and hospitals to quickly release Medicare patients. According to Ms. Jones, there has been a dramatic increase in demand for home health nursing services by Medicare patients. These patients are still seriously ill upon release from the hospital and in need of very skilled nursing care. This type of care frequently cannot be adequately provided by home health nurses who can only attend to the patient for a few hours a week. In addition, these high level care patients are diverting home health resources from others also in need of their services (such as children).

Another physician witness stated that when admitting a Medicare patient who he felt required hospitalization, but who did not necessarily meet DRG guidelines for admission, he would prescribe certain procedures that the patient may not need in order to have the patient meet those admission requirements. Dr. Hunter, who is Chairman of a hospital utilization review committee, related incidents in which the PRO denied payment for the patient's stay. When the hospital appealed the denial, the process dragged on for an extensive period of time, and because of the number of denials from that particular hospital, the PRO began to review 100 percent of the Medicare admissions to that hospital, though final decisions on the appeals were still pending. Another physician contended that the rigid DRG guidelines reduces the fine art of medicine to a bureaucratic manual. These guidelines fail to take into consideration the severity for the very old of some ailments that would be considered relatively minor to younger persons, and that the elderly are generally characterized by complex or multiple illnesses.

How extensive are these problems? Existing Medicare data do not allow a precise answer to be given. These problems are more severe and widespread than current HCFA estimates would indicate, because HCFA's judgments are based upon the very limited information available from Medicare's PROs. The Health Care Financing Administration has focused the PROs on a very narrow and incomplete set of quality issues, and therefore HCFA's assessment of quality of care is seriously deficient.

Dr. Thomas Dehn, speaking on behalf of the American Medical Peer Review Association [AMPRA], believes that the Quality Assurance System outlined by HCFA in the PRO program is a start toward developing a comprehensive review effort but must be expanded. The Association is concerned that an increasingly competitive and efficiency driven medical marketplace may threaten the overall quality of patient care, particular for the poor and elderly. He, as well as other representatives of PROs from across the country, feel that the scope of their reviews must be expanded to include quality and discharge screens to assist PROs in the identification of quality problems, and that their mandate be further expanded to encompass a wider spectrum of health care services including monitoring and evaluating health care services in ambulatory settings, nursing homes, and home health care.

## MEDICARE DRG'S: CHALLENGES FOR POST-HOSPITAL CARE, WASHINGTON, D.C., OCTOBER 24, 1985, HON. JOHN HEINZ, PRESIDING

### WITNESSES

Mrs. Marie Bell, Mayfield Village, Ohio
Lydia Thomas, Ph.D., Gaithersburg, Maryland
Mrs. Marcia Susan McDonough, Osceola, Iowa (accompanied by Janet Adair, R.N.)
Ms. Bonna Cornett, A Hospital Discharge Planner, Birmingham, Alabama

Mr. John Mitchell Rutoskey, Administrator, A Skilled Nursing Facility, Birmingham, Alabama

Raymond Cogen, M.D., Medical Director, Albert Einstein Medical Center, Willowcrest-Bamberger Division, Philadelphia, Pennsylvania

Bernice Hartzell, R.N., A Home Health Nurse, Twist, Washington

William Dombi, Esq., Legal Assistance for Medicare Patients, Willimantic, Connecticut

Roland Hornbostel, Esq., Long Term Care Ombudsman, Cleveland, Ohio

Hollis Turnham, Esq., Michigan State Long Term Care Ombudsman, Lansing, Michigan

### ISSUES RAISED AND TESTIMONY SUMMARY

Internal HCFA reports to the Administrator obtained by the Committee, indicate that since the implementation of PPS there has been a 35 percent increase in hospital discharges to skilled nursing facilities and to home health care. While hospitals are discharging Medicare patients "quicker and sicker" there have not been provisions made by HCFA to accommodate their greater post-hospital needs. In fact, the reimbursement guidelines for the Skilled Nursing Facility and Home Health Care have become more stringent. Nursing home beds, particularly for chronically ill Medicaid patients, have become increasingly scarce, while home health care resources are being stretched to their limit. As a result, severely ill patients are being released to inappropriate or sub-standard nursing homes, board and care facilities or to the care of family members.

Bonna Cornett, a hospital discharge planner, testified that she frequently has no choice but to release a patient to their home, despite inadequate resources to meet their needs, because there are not beds available in nursing homes. Due to the increased demand for these beds, homes are not always willing to take patients without financial sponsors. According to Rev. Hornbostel, the situation is worst for the "heavy care" Medicaid-eligible patients.

This problem can be compounded by inconsistencies in Medicare and Medicaid reimbursement policies which vary from state to state. This was illustrated by the testimony of Dr. Raymond Cogen, the Medical Director of a prestigious skilled nursing facility. The facility, which until last year enjoyed a waiver of liability, has had to cut back on services they provide and recently experienced a 60 percent denial rate on Medicare reimbursement. Despite the increasing need for skilled nursing beds, occupancy in this particular facility is at an all time low and their continued existence is in doubt because of a very narrow definition of skilled nursing services.

Hollis Turnham presented testimony and memoranda indicating confusion inside the Office of Inspector General at HHS regarding the enforcement of the criminal penalties against nursing homes that openly extort funds from the families of Medicaid-eligible patients in need of care. No federal agency has yet enforced the 1977 law in this area, despite repeated acknowledgements of the illegality of the actions under scrutiny.

William Dombi, an attorney who assists Medicare beneficiaries in filing appeals of denied Home Health and Skilled Nursing facility benefits, testified that HCFA has given extra-legal and illegal guidance to its fiscal intermediaries with the intent of restricting availability of these benefits. When these denials are appealed, over 70% are overturned in favor of the beneficiaries' right to obtain the services.

### MEDICARE DRG'S: THE GOVERNMENT'S ROLE IN ENSURING QUALITY, WASHINGTON, D.C. NOVEMBER 12, 1985, HON. JOHN HEINZ, CHAIRMAN, PRESIDING

#### WITNESSES

Eleanor Chelimsky, Director, Program Evaluation and Methodology Division, General Accounting Office, Washington, D.C.
C. McClain Haddow, Acting Administrator, Health Care Financing Administration, Washington, D.C.
Leon Malmud, M.D., Temple University Hospital, Philadelphia, Pennsylvania
Susan Horn, Ph.D., The John Hopkins Medical Institutions, Baltimore, Maryland
Vita Ostrander, American Association of Retired Persons, Washington, D.C.
Judy Waxman, National Health Law Program, Washington, D.C.
Catherine Hawes, Ph.D., Research Triangle Institute, Triangle Park, North Carolina
Gerald Eggert, Ph.D., Monroe County Long Term Care Program, Inc., Rochester, New York

#### ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of this hearing was to determine the nature and extent of quality of care problems under Medicare's Prospective Payment System, as well as to explore policy options to address those problems. According to Eleanor Chelimsky of the General Accounting Office, the means to monitor the effect of PPS on the quality of care received by Medicare beneficiaries are available. Nevertheless, the Health Care Financing Administration cannot be fully aware of the extent of the problem because they have failed to collect statistically valid data on the effects of PPS on quality of care. They therefore have no basis for concluding that PPS has or has not resulted in reduced quality of care to Medicare beneficiaries.

In response to the Senate Aging Committee inquiry into the problem of premature and inappropriate discharges, C. McClain Haddow, Acting Administrator of HCFA, explained that the agency has more provisions in the coming contract period with the PRO's to expand their scope of work. Under the new scope of work, PROs would be required to review all readmissions within 15 days of discharge (instead of the current 7 days), review a sample of all discharges to determine whether any were premature or represented inappropriate transfers, identify inadequate planning and review short hospital stays to assure inappropriate discharge did not occur. Mr. Haddow contends that while the Committee has discovered anecdotal evidence of early discharge that HCFA will not tolerate, these cases are not indicative of a systemic problem.

In written testimony, Dr. Bruce Vladek, President of the United Hospital Fund, stated that PPS is a good mechanism for Medicare cost containment, but changes to the present system are necessary to ensure quality care for Medicare beneficiaries. Dr. Leon Malmud pointed out that one serious flaw in the PPS is the inflexibility of the DRGs to the severity of patient illness. Along the same line, Dr. Susan Horn dramatized, using several examples, how the lack of a severity adjustment leads to underpayment and incentives to prematurely discharge patients. According to Dr. Horn, adjusting the DRG payment rates to incorporate a severity of illness scale would make great strides in eliminating the incentives for early discharge presently found in the system. Vita Ostrander, President of AARP and a member of the American Medical Peer Review Association executive board, reaffirmed points brought out in the first two hearings that HCFA should provide for increased monitoring of quality of care and give more attention to the increased needs for access to post-hospital care. Dr. Catherine Hawes described the problems facing the long term care system and suggested needed reforms including comprehensive needs assessment for patients upon discharge from the hospital, and stricter and more uniform certification standards for long term care facilities. Judy Waxman of the National Health Law Project made recommendations on the need to broaden patient rights of appeal of hospital discharges and improved notification procedures so that patients are informed of their rights. Dr. Eggert described the Monroe County Long Term Care Project in New York, an alternative long term facility which could serve as a model design for quality and cost efficient long term care.

### CHALLENGES FOR WOMEN: TAKING CHARGE, TAKING CARE, CINCINNATI, OHIO, NOVEMBER 18, 1985, HON. JOHN GLENN, RANKING MEMBER, PRESIDING

#### WITNESSES

Robert Binstock, Ph.D., Henry R. Luce, Professor of Aging, Health and Society, Case Western Reserve University, Ohio
Lillian Kern, Judge, Domestic Relations Court, Dayton, Ohio
Charlotte Birdsall, City Housing Planner, Cincinnati, Ohio
Joyce Cochenour, National Marketing Manager, Mature Outlook, Inc., Glenview, Illinois
Bernadine Tatman, family caregiver, Cincinnati, Ohio
Diana Trenkamp, President, Alzheimer's Disease and Related Disorders Association Chapter, Cincinnati, Ohio
Joan Nicholas, United Home Care, Cincinnati, Ohio

#### ISSUES RAISED AND TESTIMONY SUMMARY

Senator Glenn chaired this hearing which focused on the changing American family and the impact of these changes on women and society. The traditional notion of the family is undergoing profound changes: families are smaller; divorce rates are higher; women are in the workforce in unprecedented numbers; many heads-of-households are single women; and, there is a dramatic increase in the number of Americans living beyond age 85.

A major issue raised was the financial and emotional cost to the family of providing for the health and long-term care needs of elderly members. Testimony rebutted the myth that families are abandoning their elderly members; indeed, families, especially women caregivers, are performing heroically to assist their aged and frail members. Particularly hard hit by stressful demands is the "sandwich generation"—women who are assisting both their children and a dependent spouse or parent. Witnesses stressed the importance of respite care, support groups and other services for caregivers; health insurance to cover long-term care; and training, job security and benefits for paid home care workers who are primarily women.

Other issues discussed include problems of divorced women with regard to income and health insurance; and the housing needs of the changing family, especially women finding themselves in poverty for the first time. A city housing planner spoke of the housing needs of the changing family, especially non-traditional households such as families headed by a single female and the widowed elderly, and of the need for expanded alternatives such as home sharing, low-cost apartment cooperatives, and transitional housing for recently divorced women and their children who are at risk of being "on the street." Also discussed was emerging corporate awareness of a new aging market and targeting services and products that are responsive to the values and needs of an older population.

### THE RELATIONSHIP BETWEEN NUTRITION, AGING, AND HEALTH: A PERSONAL AND SOCIAL CHALLENGE, ALBUQUERQUE, NEW MEXICO, DECEMBER 14, 1985, HON. JEFF BINGAMAN, PRESIDING

#### WITNESSES

Jeffrey Blumberg, Ph.D., Acting Associate Director, Human Nutrition Research Center on Aging, Tufts University, Boston, Massachusetts
Gert Reynolds, Albuquerque, New Mexico
Reynalda Lopez, Albuquerque, New Mexico
Preston Keevama, San Juan Pueblo, New Mexico
Susie Candelaria, Bernalillo, New Mexico
Simon Lopez, Mora, New Mexico
Rita Maes, Director, New Mexico State Agency on Aging, Santa Fe, New Mexico
Sonia F. Crow, Associate Administrator, Food and Nutrition Service, U.S. Department of Agriculture, Washington, D.C.
Evan Hadley, M.D., Chief, Geriatrics Branch, National Institute on Aging, Department of Health and Human Services, Rockville, Maryland
Wynona Town, Chief, Nutrition and Dietetics Program, Indian Health Service Headquarters West, Santa Fe, New Mexico
Robert Thompson, M.D., Assistant Professor, Department of Family, Community and Emergency Medicine, University of New Mexico, School of Medicine, Albuquerque, New Mexico

Kathryn Treat, Assistant Director, Home Economics, NM Cooperative Extension Service, New Mexico State University, Las Cruces, New Mexico

Stephanie Fallcreek, D.S.W., Director, The Institute for Gerontological Research and Education, New Mexico State University, Las Cruces, New Mexico

### ISSUES RAISED AND TESTIMONY SUMMARY

Despite new evidence of the importance of adequate nutrition to the physical and mental well-being of the elderly, specific dietary needs remain ill-defined and current research points to lack of knowledge in this are and the need for further study.

Senator Bingaman chaired this hearing and requested it to examine the following issues: the nutritional status and dietary requirements of the elderly; age-related disease and the role of nutrition associated with those diseases; an overview of current knowledge on nutrition and areas for further research; an assessment of the federal meal and food programs serving the elderly; and the effectiveness of nutrition monitoring surveys an elderly populations.

Dr. Jeffrey Blumberg of the Human Nutrition Research Center on Aging at Tufts University presented the "world-view" of nutrition and its association to the improve health of senior citizens. Following Dr. Blumberg, five senior New Mexicans shared their own philosophy of diet and lifestyle. Next, state and federal government witnesses discussed the Title 6 meal programs under the Older Americans Act, the Food Stamp program, nutrition education and research, and nutrition monitoring. The final panel provided "food for thought" and recommended improved nutrition education and accountability under Title 6 meal programs; increased awareness and treatment by health care professionals to nutritional deficiencies of their elderly patients; and more active involvement of Department of Agriculture extension service agents in nutrition education to seniors.

The witness testimony identified key areas for further study and follow-up: 1) Develop Recommended Dietery Allowance guidelines for Americans 51 years and over; 2) Determine the level of understanding of age, disease, and nutrition and whether it is sufficient to propose practical dietary guidelines to prevent or retard those diseases found associated; 3) Analyze current federal nutrition surveys and monitoring and improve methodology and dissemination of information to the public; 4) Ensure that federal health and nutrition education material includes the most up-to-date information and advive.

Senator Bingaman agreed with the witnesses that nutrition may be the single most important component of preventive health care for seniors and should be included in the Committee's discussion of quality of care issues.

## Supplement 2

## COMMITTEE PRINTS AND REPORTS PRINTED BY THE SPECIAL COMMITTEE ON AGING IN 1985

1. DEVELOPMENTS IN AGING: 1984: VOLUME 1, FEBRUARY 1985
2. DEVELOPMENTS IN AGING: 1984; VOLUME 2, FEBRUARY 1985
3. HEALTH AND EXTENDED WORKLIFE, FEBRUARY 1985
4. PERSONNEL PRACTICES FOR AN AGING WORK-FORCE: PRIVATE SECTOR EXAMPLES, FEBRUARY 1985
5. 10TH ANNIVERSARY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, APRIL 1985
6. PUBLICATIONS LIST, APRIL 1985
7. COMPILATION OF THE OLDER AMERICANS ACT OF 1965 and RELATED PROVISIONS OF THE LAW, JUNE 1985
8. AMERICA IN TRANSITION: AN AGING SOCIETY 1984-85 EDITION, JUNE 1985
9. 50 YEARS OF SOCIAL SECURITY: PAST ACHIEVEMENTS AND FUTURE CHALLENGES, AUGUST 1985
10. HOW OLDER AMERICANS LIVE: AN ANALYSIS OF CENSUS DATA, OCTOBER 1985
11. THE 50TH ANNIVERSARY OF SOCIAL SECURITY COMMITTEE BRIEFING, AUGUST 13, 1985

## Supplement 3

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Supplement 4

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## REPORTS AND COMMITTEE PRINTS

Developments in Aging, 1959 to 1963, Report No. 8, February 1963.**
Developments in Aging, 1963 and 1964, Report No. 124, March 1965.**
Developments in Aging, 1965, Report No. 1073, March 1966.**
Developments in Aging, 1966, Report No. 169, April 1967.**
Developments in Aging, 1967, Report No. 1098, April 1968.**
Developments in Aging, 1968, Report No. 91-119, April 1969.**
Developments in Aging, 1969, Report No. 91-875, May 1970.**
Developments in Aging, 1970, Report No. 92-46, March 1971.**
Developments in Aging: 1971 and January-March 1972, Report No. 92-784, May 1972.**
Developments in Aging: 1972 and January-March 1973, Report No. 93-147, May 1973.**
Developments in Aging: 1973 and January-March 1974, Report No. 93-846, May 1974.**
Developments in Aging: 1974 and January-April 1975, Report No. 94-250, June 1975.**
Developments in Aging: 1975 and January-May 1976—Part 1, Report No. 94-998, June 1976.**
Developments in Aging: 1975 and January-May 1976—Part 2, Report No. 94-998, June 1976.**
Developments in Aging: 1976—Part 1, Report No. 95-88, April 1977.**
Developments in Aging: 1976—Part 2, Report No. 95-88, April 1977.**
Developments in Aging: 1977—Part 1, Report No. 95-771, April 1978.**
Developments in Aging: 1977—Part 2, Report No. 95-771, April 1978.**
Developments in Aging: 1978—Part 1, Report No. 96-55, March 1979.**
Developments in Aging: 1978—Part 2, Report No. 96-55, March 1979.**
Developments in Aging: 1979—Part 1, Report No. 96-613, February 1980.**
Developments in Aging: 1979—Part 2, Report No. 96-613, February 1980.**
Developments in Aging: 1980—Part 1, Report No. 97-62, May 1981.**
Developments in Aging: 1980—Part 2, Report No. 97-62, May 1981.**
Developments in Aging: 1981—Volume 1, Report No. 97-314, March 1982.**
Developments in Aging: 1981—Volume 2, Report No. 97-314, March 1982.***
Developments in Aging: 1982—Volume 1, Report No. 98-13, February 1983.**

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Developments in Aging: 1982—Volume 2, Report No. 98-13, February 1983.**

Developments in Aging: 1983—Volume 1, Report No. 98-360, February 1984—$13.*

Developments in Aging: 1983—Volume 2, Report No. 98-360, February 1984—$8.*

Developments in Aging: 1984—Volume 1, Report No. 99-5 , February 1985—$9.

Developments in Aging: 1984—Volume 2, Report No. 99-5 , February 1985—$8.

## 1961

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 1961.**

The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 1961.**

New Population Facts on Older Americans, 1960, committee print, May 1961.**

Basic Facts on the Health and Economic Status of Older Americans, staff report, committee print, June 1961.**

Health and Economic Conditions of the American Aged, committee print, June 1961.**

State Action To Implement Medical Programs for the Aged, committee print, June 1961.**

A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.**

Mental Illness Among Older Americans, committee print, September 1961.**

## 1962

Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 1962.**

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 1962.**

Statistics on Older People: Some Current Facts About the Nation's Older People, June 1962.**

Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print, June 1962.**

Housing for the Elderly, committee print, August 1962.**

Some Current Facts About the Nation's Older People, October 1962.**

## 1963

A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, committee print, June 1963.**

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Medical Assistance for the Aged: The Kerr-Mills Program, 1960–63, committee print, October 1963.**

## 1964

Blue Cross and Private Health Insurance Coverage of Older Americans, committee print, July 1964.**

Increasing Employment Opportunities for the Elderly—Recommendations and Comment, committee print, August 1964.**

Services for Senior Citizens—Recommendations and Comment, Report No. 1542, September 1964.**

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963–64, committee print, October 1964.**

## 1965

Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations: 1964, committee print, January 1965.**

Extending Private Pension Coverage, committee print, June 1965.**

Health Insurance and Related Provisions of Public Law 89–97, The Social Security Amendments of 1965, committee print, October 1965.**

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, committee print, November 1965.**

## 1966

Services to the Elderly on Public Assistance, committee print, March 1966.**

The War on Poverty As It Affects Older Americans, Report No. 1287, June 1966.**

Needs for Services Revealed by Operation Medicare Alert, committee print, October 1966.**

Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 1966.**

Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print, December 1966.**

## 1967

Reduction of Retirement Benefits Due to Social Security Increases, committee print, August 1967.**

## 1969

Economics of Aging: Toward a Full Share in Abundance, committee print, March 1969.** [1]

Homeownership Aspects of the Economics of Aging, working paper, factsheet, July 1969.** [1]

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[1] Working paper incorporated as an appendix to the hearing.

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Health Aspects of the Economics of Aging, committee print, July 1969 (revised).** [1]

Social Security for the Aged: International Perspectives, committee print, August 1969.** [1]

Employment Aspects of the Economics of Aging, committee print, December 1969.** [1]

## 1970

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, committee print, January 1970.** [1]

The Stake of Today's Workers in Retirement Security, committee print, April 1970.** [1]

Legal Problems Affecting Older Americans, committee print, August 1970.** [1]

Income Tax Overpayments by the Elderly, Report No. 91-1464, December 1970.**

Older Americans and Transportation: A Crisis in Mobility, Report No. 91-1520, December 1970.**

Economics of Aging: Toward a Full Share in Abundance, Report No. 91-1548, December 1970.**

## 1971

Medicare, Medicaid Cutbacks in California, working paper, factsheet, May 10, 1971.** [1]

The Nation's Stake in the Employment of Middle-Aged and Older Persons, committee print, July 1971.**

The Administration on Aging—Or a Successor?, committee print, October 1971.**

Alternatives to Nursing Home Care: A Proposal, committee print, October 1971.**

Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92-433, November 1971.**

The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92-450, November 1971.**

Advisory Council on the Elderly American Indian, committee print, November 1971.**

Elderly Cubans in Exile, committee print, November 1971.**

A Pre-White House Conference on Aging: Summary of Developments and Data, Report No. 92-505, November 1971.**

Research and Training in Gerontology, committee print, November 1971.**

Making Services for the Elderly Work: Some Lessons From the British Experience, committee print, November 1971.**

1971 White House Conference on Aging, a report to the delegates from the conference sections and special concerns sessions, Document No. 92-53, December 1971.**

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[1] Working paper incorporated as an appendix to the hearing.

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## 1972

Home Health Services in the United States, committee print, April 1972.**

Proposals To Eliminate Legal Barriers Affecting Elderly Mexican-Americans, committee print, May 1972.**

Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees, committee print, May 1972.**

Action on Aging Legislation in 92d Congress, committee print, October 1972.**

Legislative History of the Older Americans Comprehensive Services Amendments of 1972, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, December 1972.**

## 1973

The Rise and Threatened Fall of Service Programs for the Elderly, committee print, March 1973.**

Housing for the Elderly: A Status Report, committee print, April 1973.**

Older Americans Comprehensive Services Amendments of 1973, committee print, June 1973.**

Home Health Services in the United States: A Working Paper on Current Status, committee print, July 1973.**

Economics of Aging: Toward a Full Share in Abundance, index to hearings and report, committee print, July 1973.**

Research on Aging Act, 1973, Report No. 93-299, committee print, July 1973.**

Post-White House Conference on Aging Reports, 1973, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, September 1973.**

Improving the Age Discrimination Law, committee print, September 1973.**

## 1974

The Proposed Fiscal 1975 Budget: What It Means for Older Americans, committee print, February 1974.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, February 1974.**

Developments and Trends in State Programs and Services for the Elderly, committee print, November 1974.**

Nursing Home Care in the United States: Failure in Public Policy:**

- Introductory Report, Report No. 93-1420, November 1974.
- Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print, December 1974.
- Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," committee print, January 1975.

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Nursing Home Care—Continued

Supporting Paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," committee print, February 1975.

Supporting Paper No. 4, "Nurses in Nursing Homes: The Heavy Burden (the Reliance on Untrained and Unlicensed Personnel)," committee print, April 1975.

Supporting Paper No. 5, "The Continuing Chronicle of Nursing Home Fires," committee print, August 1975.

Supporting Paper No. 6, "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care," committee print, September 1975.

Supporting Paper No. 7, "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)," committee print, March 1976.

Private Health Insurance Supplementary to Medicare, committee print, December 1974.**

## 1975

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1975.**

Senior Opportunities and Services (Directory of Programs), committee print, February 1975.**

Action on Aging Legislation in 93d Congress, committee print, February 1975.**

The Proposed Fiscal 1976 Budget: What It Means for Older Americans, committee print, February 1975.**

Future Directions in Social Security, Unresolved Issues: An Interim Staff Report, committee print, March 1975.**

Women and Social Security: Adapting to a New Era, working paper, committee print, October 1975.**

Congregate Housing for Older Adults, Report No. 94-478, November 1975.**

## 1976

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1976.**

The Proposed Fiscal 1977 Budget: What It Means for Older Americans, committee print, February 1976.**

Fraud and Abuse Among Clinical Laboratories, Report No. 94-944, June 1976.**

Recession's Continuing Victim: The Older Worker, committee print, July 1976.**

Fraud and Abuse Among Practitioners Participating in the Medicaid Program, committee print, August 1976.**

Adult Day Facilities for Treatment, Health Care, and Related Services, committee print, September 1976.**

Termination of Social Security Coverage: The Impact on State and Local Government Employees, committee print, September 1976.**

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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Witness Index and Research Reference, committee print, November 1976.**

Action on Aging Legislation in 94th Congress, committee print, November 1976.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1976.**

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The Proposed Fiscal 1978 Budget: What It Means for Older Americans, committee print, March 1977.**

Kickbacks Among Medicaid Providers, Report No. 95-320, June 1977.**

Protective Services for the Elderly, committee print, July 1977.**

The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy, committee print, August 1977.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1977.**

## 1978

The Proposed Fiscal 1979 Budget: What It Means for Older Americans, committee print, February 1978.**

Paperwork and the Older Americans Act: Problems of Implementing Accountability, committee print, June 1978.**

Single Room Occupancy: A Need for National Concern, committee print, June 1978.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1978.**

Action on Aging Legislation in the 95th Congress, committee print, December 1978.**

## 1979

The Proposed Fiscal 1980 Budget: What It Means for Older Americans, committee print, February 1979.**

Energy Assistance Programs and Pricing Policies in the 50 States To Benefit Elderly, Disabled, or Low-Income Households, committee print, October 1979.**

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## 1980

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1980.**

The Proposed Fiscal 1981 Budget: What It Means for Older Americans, committee print, February 1980.**

Emerging Options for Work and Retirement Policy (An Analysis of Major Income and Employment Issues With an Agenda for Research Priorities), committee print, June 1980.**

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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Summary of Recommendations and Surveys on Social Security and Pension Policies, committee print, October 1980.**

Innovative Developments in Aging: State Level, committee print, October 1980.**

State Offices on Aging: History and Statutory Authority, committee print, December 1980.**

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State and Local Government Terminations of Social Security Coverage, committee print, December 1980.**

## 1981

The Proposed Fiscal Year 1982 Budget: What It Means for Older Americans, committee print, April 1981.**

Action on Aging Legislation in the 96th Congress, committee print, April 1981.**

Energy and the Aged, committee print, August 1981.**

1981 Federal Income Tax Legislation: How It Affects Older Americans and Those Planning for Retirement, committee print, August 1981.**

Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, committee print, September 1981.**

Toward a National Older Worker Policy, committee print, September 1981.**

Crime and the Elderly—What You Can Do, committee print, September 1981.**

Social Security in Europe: The Impact of an Aging Population, committee print, December 1981.***

Background Materials Relating to Office of Inspector General, Department of Health and Human Services Efforts To Combat Fraud, Waste, and Abuse, committee print, December 1981.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1981.**

A Guide to Individual Retirement Accounts (IRA's), committee print, December 1981, stock No. 052-070-05666-5—$2.

## 1982

Social Security Disability: Past, Present, and Future, committee print, March 1982.**

The Proposed Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, March 1982.**

Linkages Between Private Pensions and Social Security Reform, committee print, April 1982.**

Health Care Expenditures for the Elderly: How Much Protection Does Medicare Provide?, committee print, April 1982.**

Turning Home Equity Into Income for Older Homeowners, committee print, July 1982, stock No. 052-070-05753-0—$1.25.

Aging and the Work Force: Human Resource Strategies, committee print, August 1982.***

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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Fraud, Waste, and Abuse in the Medicare Pacemaker Industry, committee print, September 1982, stock No. 052-070-05777-7—$6.*

Congressional Action on the Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, November 1982.**

Equal Employment Opportunity Commission Enforcement of the Age Discrimination in Employment Act: 1979 to 1982, committee print, November 1982.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1982.**

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Consumer Frauds and Elderly Persons: A Growing Problem, committee print, February 1983, stock No. 052-070-05823-4—$4.50.

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Prospects for Medicare's Hospital Insurance Trust Fund, committee print, March 1983.***

The Proposed Fiscal Year 1984 Budget: What It Means for Older Americans, committee print, March 1983.**

You and Your Medicines: Guidelines for Older Americans, committee print, June 1983.***

Heat Stress and Older Americans: Problems and Solutions, committee print, July 1983.***

Current Developments in Prospective Reimbursement Systems for Financing Hospital Care, committee print, October 1983.***

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1983.**

## 1984

Medicare: Paying the Physician—History, Issues, and Options, committee print, March 1984.***

Older Americans and the Federal Budget: Past, Present, and Future, committtee print, April 1984.**

Medicare and the Health Cost of Older Americans: The Extent and Effects of Cost Sharing, committee print, April 1984, Stock No. 052-050-05916-8, $2.

The Supplemental Security Income Program: A 10-Year Overview, committee print, May 1984, Stock No. 052-050-05928-1, $6.50.*

Long-Term Care in Western Europe and Canada: Implications for the United States, committee print, July 1984.***

Turning Home Equity Into Income for Older Americans, committee print, July 1984, stock No. 052-070-05753-3, $1.25.

The Employee Retirement Income Security Act of 1974: The First Decade, committee print, August 1984, stock No. 052-070-05950-8, $5,50.*

The Costs of Employing Older Workers, committee print, September 1984.**

Rural and Small-City Elderly, committee print, September 1984.***

Section 202 Housing for the Elderly and Handicapped: A National Survey, committee print, December 1984.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1984, stock No. 052-070-05984-2, $1.25.

Health and Extended Worklife, committee print, February 1985.***

Personnel practices for an Aging Workforce: Private-Sector Examples, committee print, February 1985.***

10th Anniversary of the Employee Retirement Income Security Act of 1974, committee print, April 1985.***

Compilation of the Older Americans Act of 1965 and Related Provisions of Law, committee print, June 1985.***

America in Transition: An Aging Society, 1984-85 Edition, committee print, June 1985.***

Fifty Years of Social Security: Past Achievements and Future Challenges, committee print, August 1985.***

How Older Americans Live: An Analysis of Census Data, committee print, October 1985.***

Congressional Briefing on the 50th Anniversary of Social Security, committee print, August 13, 1985. ***

Protecting Older Americans Against the Overpayment of Income Taxes,committee print, January 1986.***

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## HEARINGS

Retirement Income of the Aging:**
- Part 1. Washington, D.C., July 12 and 13, 1961.
- Part 2. St. Petersburg, Fla., November 6, 1961.
- Part 3. Port Charlotte, Fla., November 7, 1961.
- Part 4. Sarasota, Fla., November 8, 1961.
- Part 5. Springfield, Mass., November 29, 1961.
- Part 6. St. Joseph, Mo., December 11, 1961.
- Part 7. Hannibal, Mo., December 13, 1961.
- Part 8. Cape Girardeau, Mo., December 15, 1961.
- Part 9. Daytona Beach, Fla., February 14, 1962.
- Part 10. Fort Lauderdale, Fla., February 15, 1962.

Housing Problems of the Elderly:**
- Part 1. Washington, D.C., August 22 and 23, 1961.
- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

Problems of the Aging:**
- Part 1. Washington, D.C., August 23 and 24, 1961.
- Part 2. Trenton, N.J., October 23, 1961.
- Part 3. Los Angeles, Calif., October 24, 1961.
- Part 4. Las Vegas, Nev., October 25, 1961.
- Part 5. Eugene, Oreg., November 8, 1961.
- Part 6. Pocatello, Idaho, November 13, 1961.
- Part 7. Boise, Idaho, November 15, 1961.
- Part 8. Spokane, Wash., November 17, 1961.
- Part 9. Honolulu, Hawaii, November 27, 1961.
- Part 10. Lihue, Hawaii, November 29, 1961.
- Part 11. Wailuku, Hawaii, November 30, 1961.
- Part 12. Hilo, Hawaii, December 1, 1961.
- Part 13. Kansas City, Mo., December 6, 1961.

Nursing Homes:**
- Part 1. Portland, Oreg., November 6, 1961.
- Part 2. Walla Walla, Wash., November 10, 1961.
- Part 3. Hartford, Conn., November 20, 1961.
- Part 4. Boston, Mass., December 1, 1961.
- Part 5. Minneapolis, Minn., December 4, 1961.
- Part 6. Springfield, Mo., December 12, 1961.

Relocation of Elderly People:**
- Part 1. Washington, D.C., October 22 and 23, 1962.
- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.

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Relocation of Elderly People—Continued
  Part 5. Los Angeles, Calif., December 5, 1962.
  Part 6. San Francisco, Calif., December 7, 1962.
Frauds and Quackery Affecting the Older Citizen:**
  Part 1. Washington, D.C., January 15, 1963.
  Part 2. Washington, D.C., January 16, 1963.
  Part 3. Washington, D.C., January 17, 1963.
Housing Problems of the Elderly:**
  Part 1. Washington, D.C., December 11, 1963.
  Part 2. Los Angeles, Calif., January 9, 1964.
  Part 3. San Francisco, Calif., January 11, 1964.
Long-Term Institutional Care for the Aged, Washington, D.C., December 17 and 18, 1963.**
Increasing Employment Opportunities for the Elderly:**
  Part 1. Washington, D.C., December 19, 1963.
  Part 2. Los Angeles, Calif., January 10, 1964.
  Part 3. San Francisco, Calif., January 13, 1964.
Health Frauds and Quackery:**
  Part 1. San Francisco, Calif., January 13, 1964.
  Part 2. Washington, D.C., March 9, 1964.
  Part 3. Washington, D.C., March 10, 1964.
  Part 4A. Washington, D.C., April 6, 1964 (morning).
  Part 4B. Washington, D.C., April 6, 1964 (afternoon).
Services for Senior Citizens:**
  Part 1. Washington, D.C., January 16, 1964.
  Part 2. Boston, Mass., January 20, 1964.
  Part 3. Providence, R.I., January 21, 1964.
  Part 4. Saginaw, Mich., March 2, 1964.
Blue Cross and Other Private Health Insurance for the Elderly:**
  Part 1. Washington, D.C., April 27, 1964.
  Part 2. Washington, D.C., April 28, 1964.
  Part 3. Washington, D.C., April 29, 1964.
  Part 4A. Appendix.
  Part 4B. Appendix.
Deceptive or Misleading Methods in Health Insurance Sales, Washington, D.C., May 4, 1964.**
Nursing Homes and Related Long-Term Care Services:**
  Part 1. Washington, D.C., May 5, 1964.
  Part 2. Washington, D.C., May 6, 1964.
  Part 3. Washington, D.C., May 7, 1964.
Interstate Mail Order Land Sales:**
  Part 1. Washington, D.C., May 18, 1964.
  Part 2. Washington, D.C., May 19, 1964.
  Part 3. Washington, D.C., May 20, 1964.
Preneed Burial Service, Washington, D.C., May 19, 1964.**
Conditions and Problems in the Nation's Nursing Homes:**
  Part 1. Indianapolis, Ind., February 11, 1965.
  Part 2. Cleveland, Ohio, February 15, 1965.
  Part 3. Los Angeles, Calif., February 17, 1965.
  Part 4. Denver, Colo., February 23, 1965.

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Conditions and Problems in the Nation's Nursing Homes—Continued
  Part 5. New York, N.Y., August 2 and 3, 1965.
  Part 6. Boston, Mass., August 9, 1965.
  Part 7. Portland, Maine, August 13, 1965.
Extending Private Pension Coverage:**
  Part 1. Washington, D.C., March 4, 1965.
  Part 2. Washington, D.C., March 5 and 10, 1965.
The War on Poverty As It Affects Older Americans:**
  Part 1. Washington, D.C., June 16 and 17, 1965.
  Part 2. Newark, N.J., July 10, 1965.
  Part 3. Washington, D.C., January 19 and 20, 1966.
Services to the Elderly on Public Assistance:**
  Part 1. Washington, D.C., August 18 and 19, 1965.
  Part 2. Appendix.
Needs for Services Revealed by Operation Medicare Alert, Washington, D.C., June 2, 1966.**
Tax Consequences of Contributions to Needy Older Relatives, Washington, D.C., June 15, 1966.**
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, Washington, D.C., September 20, 21, and 22, 1966.**
Consumer Interests of the Elderly:**
  Part 1. Washington, D.C., January 17 and 18, 1967.
  Part 2. Tampa, Fla., February 3, 1967.
Reduction of Retirement Benefits Due to Social Security Increases, Washington, D.C., April 24 and 25, 1967.**
Retirement and the Individual:**
  Part 1. Washington, D.C., June 7 and 8, 1967.
  Part 2. Ann Arbor, Mich., July 26, 1967.
Costs and Delivery of Health Services to Older Americans:**
  Part 1. Washington, D.C., June 22 and 23, 1967.
  Part 2. New York, N.Y., October 19, 1967.
  Part 3. Los Angeles, Calif., October 16, 1968.
Rent Supplement Assistance to the Elderly, Washington, D.C., July 11, 1967.**
Long-Range Program and Research Needs in Aging and Related Fields, Washington, D.C., December 5 and 6, 1967.**
Hearing Loss, Hearing Aids, and the Elderly, Washington, D.C., July 18 and 19, 1968.**
Usefulness of the Model Cities Program to the Elderly:**
  Part 1. Washington, D.C., July 23, 1968.
  Part 2. Seattle, Wash., October 14, 1968.
  Part 3. Ogden, Utah, October 24, 1968.
  Part 4. Syracuse, N.Y., December 9, 1968.
  Part 5. Atlanta, Ga., December 11, 1968.
  Part 6. Boston, Mass., July 11, 1969.
  Part 7. Washington, D.C., October 14 and 15, 1969.
Adequacy of Services for Older Workers, Washington, D.C., July 24, 25, and 29, 1968.**

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Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans: **
- Part 1. Los Angeles, Calif., December 17, 1968.
- Part 2. El Paso, Tex., December 18, 1968.
- Part 3. San Antonio, Tex., December 19, 1968.
- Part 4. Washington, D.C., January 14 and 15, 1969.
- Part 5. Washington, D.C., November 20 and 21, 1969.

Economics of Aging: Toward a Full Share in Abundance:**
- Part 1. Washington, D.C., survey hearing, April 29 and 30, 1969.
- Part 2. Ann Arbor, Mich., consumer aspects, June 9, 1969.
- Part 3. Washington, D.C., health aspects, July 17 and 18, 1969.
- Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.
- Part 5. Paramus, N.J., central suburban area, August 14, 1969.
- Part 6. Cape May, N.J., retirement community, August 15, 1969.
- Part 7. Washington, D.C., international perspectives, August 25, 1969.
- Part 8. Washington, D.C., national organizations, October 29, 1969.
- Part 9. Washington, D.C., employment aspects, December 18 and 19, 1969.
- Part 10A. Washington, D.C., pension aspects, February 17, 1970.
- Part 10B. Washington, D.C., pension aspects, February 18, 1970.
- Part 11. Washington, D.C., concluding hearing, May 4, 5, and 6, 1970.

The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns, Washington, D.C., July 25, 1969.**

Trends in Long-Term Care:**
- Part 1. Washington, D.C., July 30, 1969.
- Part 2. St. Petersburg, Fla., January 9, 1970.
- Part 3. Hartford, Conn., January 15, 1970.
- Part 4. Washington, D.C. (Marietta, Ohio, fire), February 9, 1970.
- Part 5. Washington, D.C. (Marietta, Ohio, fire), February 10, 1970.
- Part 6. San Francisco, Calif., February 12, 1970.
- Part 7. Salt Lake City, Utah, February 13, 1970.
- Part 8. Washington, D.C., May 7, 1970.
- Part 9. Washington, D.C. (Salmonella), August 19, 1970.
- Part 10. Washington, D.C. (Salmonella), December 14, 1970.
- Part 11. Washington, D.C., December 17, 1970.
- Part 12. Chicago, Ill., April 2, 1971.
- Part 13. Chicago, Ill., April 3, 1971.
- Part 14. Washington, D.C., June 15, 1971.
- Part 15. Chicago, Ill., September 14, 1971.
- Part 16. Washington, D.C., September 29, 1971.
- Part 17. Washington, D.C., October 14, 1971.

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Trends in Long-Term Care—Continued
  Part 18. Washington, D.C., October 28, 1971.
  Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.
  Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971.
  Part 20. Washington, D.C., August 10, 1972.
  Part 21. Washington, D.C., October 10, 1973.
  Part 22. Washington, D.C., October 11, 1973.
  Part 23. New York, N.Y., January 21, 1975.
  Part 24. New York, N.Y., February 4, 1975.
  Part 25. Washington, D.C., February 19, 1975.
  Part 26. Washington, D.C., December 9, 1975.
  Part 27. New York, N.Y., March 19, 1976.
Older Americans in Rural Areas:**
  Part 1. Des Moines, Iowa, September 8, 1969.
  Part 2. Majestic-Freeburn, Ky., September 12, 1969.
  Part 3. Fleming, Ky., September 12, 1969.
  Part 4. New Albany, Ind., September 16, 1969.
  Part 5. Greenwood, Miss., October 9, 1969.
  Part 6. Little Rock, Ark., October 10, 1969.
  Part 7. Emmett, Idaho, February 24, 1970.
  Part 8. Boise, Idaho, February 24, 1970.
  Part 9. Washington, D.C., May 26, 1970.
  Part 10. Washington, D.C., June 2, 1970.
  Part 11. Dogbone-Charleston, W. Va., October 27, 1970.
  Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.
Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970.**
Sources of Community Support for Federal Programs Serving Older Americans:**
  Part 1. Ocean Grove, N.J., April, 18, 1970.
  Part 2. Washington, D.C., June 8 and 9, 1970.
Legal Problems Affecting Older Americans:**
  Part 1. St. Louis, Mo., August 11, 1970.
  Part 2. Boston, Mass., April 30, 1971.
Evaluation of Administration on Aging and Conduct of White House Conference on Aging:**
  Part 1. Washington, D.C., March 25, 1971.
  Part 2. Washington, D.C., March 29, 1971.
  Part 3. Washington, D.C., March 30, 1971.
  Part 4. Washington, D.C., March 31, 1971.
  Part 5. Washington, D.C., April 27, 1971.
  Part 6. Orlando, Fla., May 10, 1971.
  Part 7. Des Moines, Iowa, May 13, 1971.
  Part 8. Boise, Idaho, May 28, 1971.
  Part 9. Casper, Wyo., August 13, 1971.
  Part 10. Washington, D.C., February 3, 1972.
Cutbacks in Medicare and Medicaid Coverage:**
  Part 1. Los Angeles, Calif., May 10, 1971.
  Part 2. Woonsocket, R.I., June 14, 1971.
  Part 3. Providence, R.I., September 20, 1971.

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Unemployment Among Older Workers: **
- Part 1. South Bend, Ind., June 4, 1971.
- Part 2. Roanoke, Ala., August 10, 1971.
- Part 3. Miami, Fla., August 11, 1971.
- Part 4. Pocatello, Idaho, August 27, 1971.

Adequacy of Federal Response to Housing Needs of Older Americans:**
- Part 1. Washington, D.C., August 2, 1971.
- Part 2. Washington, D.C., August 3, 1971.
- Part 3. Washington, D.C., August 4, 1971.
- Part 4. Washington, D.C., October 28, 1971.
- Part 5. Washington, D.C., October 29, 1971.
- Part 6. Washington, D.C., July 31, 1972.
- Part 7. Washington, D.C., August 1, 1972.
- Part 8. Washington, D.C., August 2, 1972.
- Part 9. Boston, Mass., October 2, 1972.
- Part 10. Trenton, N.J., January 17, 1974.
- Part 11. Atlantic City, N.J., January 18, 1974.
- Part 12. East Orange, N.J., January 19, 1974.
- Part 13. Washington, D.C., October 7, 1975.
- Part 14. Washington, D.C., October 8, 1975.

Flammable Fabrics and Other Fire Hazards to Older Americans, Washington, D.C., October 12, 1971.**

A Barrier-Free Environment for the Elderly and the Handicapped:**
- Part 1. Washington, D.C., October 18, 1971.
- Part 2. Washington, D.C., October 19, 1971.
- Part 3. Washington, D.C., October 20, 1971.

Death With Dignity: An Inquiry Into Related Public Issues:**
- Part 1. Washington, D.C., August 7, 1972.
- Part 2. Washington, D.C., August 8, 1972.
- Part 3. Washington, D.C., August 9, 1972.

Future Directions in Social Security:**
- Part 1. Washington, D.C., January 15, 1973.
- Part 2. Washington, D.C., January 22, 1973.
- Part 3. Washington, D.C., January 23, 1973.
- Part 4. Washington, D.C., July 25, 1973.
- Part 5. Washington, D.C., July 26, 1973.
- Part 6. Twin Falls, Idaho, May 16, 1974.
- Part 7. Washington, D.C., July 15, 1974.
- Part 8. Washington, D.C., July 16, 1974.
- Part 9. Washington, D.C., March 18, 1975.
- Part 10. Washington, D.C., March 19, 1975.
- Part 11. Washington, D.C., March 20, 1975.
- Part 12. Washington, D.C., May 1, 1975.
- Part 13. San Francisco, Calif., May 15, 1975.
- Part 14. Los Angeles, Calif., May 16, 1975.
- Part 15. Des Moines, Iowa, May 19, 1975.
- Part 16. Newark, N.J., June 30, 1975.
- Part 17. Toms River, N.J., September 8, 1975.
- Part 18. Washington, D.C., October 22, 1975.

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Future Directions in Social Security—Continued
    Part 19. Washington, D.C., October 23, 1975.
    Part 20. Portland, Oreg., November 24, 1975.
    Part 21. Portland, Oreg., November 25, 1975.
    Part 22. Nashville, Tenn., December 6, 1975.
    Part 23. Boston, Mass., December 19, 1975.
    Part 24. Providence, R.I., January 26, 1976.
    Part 25. Memphis, Tenn., February 13, 1976.
Fire Safety in Highrise Buildings for the Elderly:**
    Part 1. Washington, D.C., February 27, 1973.
    Part 2. Washington, D.C., February 28, 1973.
Barriers to Health Care for Older Americans:**
    Part 1. Washington, D.C., March 5, 1973.
    Part 2. Washington, D.C., March 6, 1973.
    Part 3. Livermore Falls, Maine, April 23, 1973.
    Part 4. Springfield, Ill., May 16, 1973.
    Part 5. Washington, D.C., July 11, 1973.
    Part 6. Washington, D.C., July 12, 1973.
    Part 7. Coeur d'Alene, Idaho, August 4, 1973.
    Part 8. Washington, D.C., March 12, 1974.
    Part 9. Washington, D.C., March 13, 1974.
    Part 10. Price, Utah, April 20, 1974.
    Part 11. Albuquerque, N. Mex., May 25, 1974.
    Part 12. Santa Fe, N. Mex., May 25, 1974.
    Part 13. Washington, D.C., June 25, 1974.
    Part 14. Washington, D.C., June 26, 1974.
    Part 15. Washington, D.C., July 9, 1974.
    Part 16. Washington, D.C., July 17, 1974.
Training Needs in Gerontology:**
    Part 1. Washington, D.C., June 19, 1973.
    Part 2. Washington, D.C., June 21, 1973.
    Part 3. Washington, D.C., March 7, 1975.
Hearing Aids and the Older American:**
    Part 1. Washington, D.C., September 10, 1973.
    Part 2. Washington, D.C., September 11, 1973.
Transportation and the Elderly: Problems and Progress:**
    Part 1. Washington, D.C., February 25, 1974.
    Part 2. Washington, D.C., February 27, 1974.
    Part 3. Washington, D.C., February 28, 1974.
    Part 4. Washington, D.C., April 9, 1974.
    Part 5. Washington, D.C., July 29, 1975.
    Part 6. Washington, D.C., July 12, 1977.
Improving Legal Representation for Older Americans:**
    Part 1. Los Angeles, Calif., June 14, 1974.
    Part 2. Boston, Mass., August 30, 1976.
    Part 3. Washington, D.C., September 28, 1976.
    Part 4. Washington, D.C., September 29, 1976.
Establishing a National Institute on Aging, Washington, D.C., August 1, 1974.**
The Impact of Rising Energy Costs on Older Americans:**
    Part 1. Washington, D.C., September 24, 1974.

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The Impact of Rising Energy Costs—Continued
  Part 2. Washington, D.C., September 25, 1974.
  Part 3. Washington, D.C., November 7, 1975.
  Part 4. Washington, D.C., April 5, 1977.
  Part 5. Washington, D.C., April 7, 1977.
  Part 6. Washington, D.C., June 28, 1977.
  Part 7. Missoula, Mont., February 14, 1979.
The Older Americans Act and the Rural Elderly, Washington, D.C., April 28, 1975.**
Examination of Proposed Section 202 Housing Regulations:**
  Part 1. Washington, D.C., June 6, 1975.
  Part 2. Washington, D.C., June 26, 1975.
The Recession and the Older Worker, Chicago, Ill., August 14, 1975.**
Medicare and Medicaid Frauds:**
  Part 1. Washington, D.C., September 26, 1975.
  Part 2. Washington, D.C., November 13, 1975.
  Part 3. Washington, D.C., December 5, 1975.
  Part 4. Washington, D.C., February 16, 1976.
  Part 5. Washington, D.C., August 30, 1976.
  Part 6. Washington, D.C., August 31, 1976.
  Part 7. Washington, D.C., November 17, 1976.
  Part 8. Washington, D.C., March 8, 1977.
  Part 9. Washington, D.C., March 9, 1977.
Mental Health and the Elderly, Washington, D.C., September 29, 1975.**
Proprietary Home Health Care (joint hearing with House Select Committee on Aging), Washington, D.C., October 28, 1975.**
Proposed USDA Food Stamp Cutbacks for the Elderly, Washington, D.C., November 3, 1975.**
The Tragedy of Nursing Home Fires: The Need for a National Commitment for Safety (joint hearing with House Select Committee on Aging), Washington, D.C., June 3, 1976.**
The Nation's Rural Elderly:**
  Part 1. Winterset, Iowa, August 16, 1976.
  Part 2. Ottumwa, Iowa, August 16, 1976.
  Part 3. Gretna, Nebr., August 17, 1976.
  Part 4. Ida Grove, Iowa, August 17, 1976.
  Part 5. Sioux Falls, S. Dak., August 18, 1976.
  Part 6. Rockford, Iowa, August 18, 1976.
  Part 7. Denver, Colo., March 23, 1977.
  Part 8. Flagstaff, Ariz., November 5, 1977.
  Part 9. Tucson, Ariz., November 7, 1977.
  Part 10. Terre Haute, Ind., November 11, 1977.
  Part 11. Phoenix, Ariz., November 12, 1977.
  Part 12. Roswell, N. Mex., November 18, 1977.
  Part 13. Taos, N. Mex., November 19, 1977.
  Part 14. Albuquerque, N. Mex., November 21, 1977.
  Part 15. Pensacola, Fla., November 21, 1977.
  Part 16. Gainesville, Fla., November 22, 1977.
  Part 17. Champaign, Ill., December 13, 1977.

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Medicine and Aging: An Assessment of Opportunities and Neglect, New York, N.Y., October 13, 1976.**

Effectiveness of Food Stamps for Older Americans:**
  Part 1. Washington, D.C., April 18, 1977.
  Part 2. Washington, D.C., April 19, 1977.

Health Care for Older Americans: The "Alternatives" Issue:**
  Part 1. Washington, D.C., May 16, 1977.
  Part 2. Washington, D.C., May 17, 1977.
  Part 3. Washington, D.C., June 15, 1977.
  Part 4. Cleveland, Ohio, July 6, 1977.
  Part 5. Washington, D.C., September 21, 1977.
  Part 6. Holyoke, Mass., October 12, 1977.
  Part 7. Tallahassee, Fla., November 23, 1977.
  Part 8. Washington, D.C., April 17, 1978.

Senior Centers and the Older Americans Act, Washington, D.C., October 20, 1977.**

The Graying of Nations: Implications, Washington, D.C., November 10, 1977.**

Tax Forms and Tax Equity for Older Americans, Washington, D.C., February 24, 1978.**

Medi-Gap: Private Health Insurance Supplements to Medicare:**
  Part 1. Washington, D.C., May 16, 1978.
  Part 2. Washington, D.C., June 29, 1978.

Retirement, Work, and Lifelong Learning:**
  Part 1. Washington, D.C., July 17, 1978.
  Part 2. Washington, D.C., July 18, 1978.
  Part 3. Washington, D.C., July 19, 1978.
  Part 4. Washington, D.C., September 8, 1978.

Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units, Washington, D.C., July 25, 1978.**

Vision Impairment Among Older Americans, Washington, D.C., August 3, 1978.**

The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and "Alternatives," Chicago, Ill., August 30, 1978.**

Condominiums and the Older Purchaser:**
  Part 1. Hallandale, Fla., November 28, 1978.
  Part 2. West Palm Beach, Fla., November 29, 1978.

Older Americans in the Nation's Neighborhoods:**
  Part 1. Washington, D.C., December 1, 1978.
  Part 2. Oakland, Calif., December 4, 1978.

Commodities and Nutrition Program for the Elderly, Missoula, Mont., February 14, 1979.**

The Effect of Food Stamp Cutbacks on Older Americans, Washington, D.C., April 11, 1979.**

Home Care Services for Older Americans: Planning for the Future, Washington, D.C., May 7 and 21, 1979.**

Federal Paperwork Burdens, With Emphasis on Medicare (joint hearing with Subcommittee on Federal Spending Practices and

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Open Government of the Senate Committee on Governmental Affairs), St. Petersburg, Fla., August 6, 1979.**
Abuse of the Medicare Home Health Program, Miami, Fla., August 28, 1979.**
Occupational Health Hazards of Older Workers in New Mexico, Grants, N. Mex., August 30, 1979.**
Energy Assistance for the Elderly:**
  Part 1. Akron, Ohio, August 30, 1979.
  Part 2. Washington, D.C., September 13, 1979.
  Part 3. Pennsauken, N.J., May 23, 1980.
  Part 4. Washington, D.C., July 25, 1980.
Regulations To Implement the Comprehensive Older Americans Act Amendments of 1978:**
  Part 1. Washington, D.C., October 18, 1979.
  Part 2. Washington, D.C., March 24, 1980.
Medicare Reimbursement for Elderly Participation in Health Maintenance Organizations and Health Benefit Plans, Philadelphia, Pa., October 29, 1979.**
Energy and the Aged: A Challenge to the Quality of Life in a Time of Declining Energy Availability, Washington, D.C., November 26, 1979.**
Adapting Social Security to a Changing Work Force, Washington, D.C., November 28, 1979.**
Aging and Mental Health: Overcoming Barriers to Service:**
  Part 1. Little Rock, Ark., April 4, 1980.
  Part 2. Washington, D.C., May 22, 1980.
Rural Elderly—The Isolated Population: A Look at Services in the 80's, Las Vegas, N. Mex., April 11, 1980.**
Work After 65: Options for the 80's:**
  Part 1. Washington, D.C., April 24, 1980.
  Part 2. Washington, D.C., May 13, 1980.
  Part 3. Orlando, Fla., July 9, 1980.
How Old Is "Old"? The Effects of Aging on Learning and Working, Washington, D.C., April 30, 1980.**
Minority Elderly: Economics and Housing in the 80's, Philadelphia, Pa., May 7, 1980.**
Maine's Rural Elderly: Independence Without Isolation, Bangor, Maine, June 9, 1980.**
Elder Abuse (joint hearing with House Select Committee on Aging), Washington, D.C., June 11, 1980.**
Crime and the Elderly: What Your Community Can Do, Albuquerque, N. Mex., June 23, 1980, stock No. 052-070-05517-1—$5.*
Possible Abuse and Maladministration of Home Rehabilitation Programs for the Elderly, Santa Fe, N. Mex., October 8, 1980, and Washington, D.C., December 19, 1980.**
Energy Equity and the Elderly in the 80's:**
  Part 1. Boston, Mass., October 24, 1980.
  Part 2. St. Petersburg, Fla., October 28, 1980.
Retirement Benefits: Are They Fair and Are They Enough?, Fort Leavenworth, Kans., November 8, 1980.**

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Social Security: What Changes Are Necessary?:**
    Part 1. Washington, D.C., November 21, 1980.
    Part 2. Washington, D.C., December 2, 1980.
    Part 3. Washington, D.C., December 3, 1980.
    Part 4. Washington, D.C., December 4, 1980.
Home Health Care: Future Policy (joint hearing with Senate Committee on Labor and Human Resources), Princeton, N.J., November 23, 1980.**
Impact of Federal Estate Tax Policies on Rural Women, Washington, D.C., February 4, 1981.**
Impact of Federal Budget Proposals on Older Americans:**
    Part 1. Washington, D.C., March 20, 1981.
    Part 2. Washington, D.C., March 27, 1981.
    Part 3. Philadelphia, Pa., April 10, 1981.
Energy and the Aged, Washington, D.C., April 9, 1981.**
Older Americans Act, Washington, D.C., April 27, 1981.**
Social Security Reform: Effect on Work and Income After Age 65, Rogers, Ark., May 18, 1981.**
Social Security Oversight:**
    Part 1 (Short-Term Financing Issues). Washington, D.C., June 16, 1981.
    Part 2 (Early Retirement). Washington, D.C., June 18, 1981.
    Part 3 (Cost-of-Living Adjustments). Washington, D.C., June 24, 1981.
Medicare Reimbursement to Competitive Medical Plans, Washington, D.C., July 29, 1981.**
Rural Access to Elderly Programs, Sioux Falls, S. Dak., August 3, 1981.**
Frauds Against the Elderly, Harrisburg, Pa., August 4, 1981.**
The Social Security System: Averting the Crisis, Evanston, Ill., August 10, 1981.**
Social Security Reform and Retirement Income Policy, Washington, D.C., September 16, 1981.**
Older Americans Fighting the Fear of Crime, Washington, D.C., September 22, 1981.**
Employment: An Option for All Ages, Rock Island, Ill., and Davenport, Iowa, October 12, 1981.**
Older Workers: The Federal Role in Promoting Employment Opportunities, Washington, D.C., October, 29, 1981.**
Rural Health Care for the Elderly: New Paths for the Future, Grand Forks, N. Dak., November 14, 1981.**
Oversight of HHS Inspector General's Effort To Combat Fraud, Waste and Abuse (joint hearing with the Senate Finance Committee), Washington, D.C., December 9, 1981.**
Alternative Approaches To Housing Older Americans, Hartford, Conn., February 1, 1982.**
Energy and the Aged: The Widening Gap, Erie, Pa., February 19, 1982.**
Hunger, Nutrition, Older Americans: The Impact of the Fiscal Year 1983 Budget, Washington, D.C., February 25, 1982.**
Problems Associated With the Medicare Reimbursement System for Hospitals, Washington, D.C., March 10, 1982.**

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Impact of the Federal Budget on the Future of Services for Older Americans (joint hearing with House Select Committee on Aging), Washington, D.C., April 1, 1982 .**
Health Care for the Elderly: What's in the Future for Long-Term Care?, Bismarck, N. Dak., April 6, 1982.**
The Impact of the Administration's Housing Proposals on Older Americans, Washington, D.C., April 23, 1982.**
Rural Older Americans: Unanswered Questions, Washington, D.C., May 19, 1982.**
The Hospice Alternative, Pittsburgh, Pa., May 24, 1982.**
Nursing Home Survey and Certification: Assuring Quality Care, Washington, D.C., July 15, 1982.**
Opportunities in Home Equity Conversion for the Elderly, Washington, D.C., July 20, 1982.**
Long-Term Health Care for the Elderly, Newark, N.J., July 26, 1982.**
Fraud, Waste, and Abuse in the Medicare Pacemaker Industry, Washington, D.C., September 10, 1982.**
Social Security Disability: The Effects of the Accelerated Review (joint hearing with Subcommittee on Civil Service, Post Office, and General Services of the Senate Committee on Governmental Affairs), Fort Smith, Ark., November 19, 1982.**
Quality Assurance Under Prospective Reimbursement Programs, Washington, D.C., February 4, 1983.**
Combating Frauds Against the Elderly, Washington, D.C., March 1, 1983.***
Energy and the Aged: The Impact of Natural Gas Deregulation, Washington, D.C., March 17, 1983.***
Social Security Reviews of the Mentally Disabled, Washington, D.C., April 7, 8, 1983.***
The Future of Medicare, Washington, D.C., April 13, 1983.**
Life Care Communities: Promises and Problems, Washington, D.C., May 25, 1983, stock No. 052-070-05880-3, $4.50.*
Drug Use and Misuse: A Growing Concern for Older Americans (joint hearing with the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging), Washington, D.C., June 28, 1983.**
Community Alternatives to Institutional Care, Harrisburg, Pa., July 6, 1983.**
Crime Against the Elderly, Los Angeles, Calif., July 6, 1983.***
Home Fire Deaths: A Preventable Tragedy, Washington, D.C., July 28, 1983.**
The Role of Nursing Homes in Today's Society, Sioux Falls, S. Dak., August 29, 1983.***
Endless Night, Endless Mourning: Living With Alzheimer's, New York, N.Y., September 12, 1983.**
Controlling Health Care Costs: State, Local, and Private Sector Initiatives, Washington, D.C., October 26, 1983, stock No. 052-070-05899-4, $3.75.
Social Security: How Well Is It Serving the Public? Washington, D.C., November 29, 1983.***

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The Crisis in Medicare: Proposals for Reform, Sioux City, Iowa, December 13, 1983.***

Social Security Disability Reviews: The Human Costs:***
  Part 1. Chicago, Ill., February 16, 1984.
  Part 2. Dallas, Tex., February 17, 1984.
  Part 3. Hot Springs, Ark., March 24, 1984.

Meeting the Present and Future Needs for Long-Term Care, Jersey City, N.J., February 27, 1984.***

Energy and the Aged: Strategies for Improving the Federal Weatherization Program, Washington, D.C., March 2, 1984.***

Medicare: Physician Payment Options, Washington, D.C., March 16, 1984.***

Reauthorization of the Older Americans Act, 1984 (joint hearing with the Subcommittee on Aging of the Senate Committee on Labor and Human Resources), Washington, D.C., March 20, 1984.***

Long-Term Care: A Look at Home and Community-Based Services, Granite City, Ill., April 13, 1984.***

Medicare: Present Problems—Future Options, Wichita, Kans., April 20, 1984.***

Sheltering America's Aged: Options for Housing and Services, Boston, Mass., April 23, 1984.***

Protecting Medicare and Medicaid Patients from Sanctioned Health Practitioners, Washington, D.C., May 1, 1984.***

A 10th Anniversary Review of the SSI Program, Washington, D.C., May 17, 1984.***

Long-Term Needs of the Elderly: A Federal-State-Private Parternship, Seattle, Wash., July 10, 1984.***

Low-Cost Housing for the Elderly: Surplus Lands and Private-Sector Initiatives, Sacramento, Calif., August 13, 1984.***

The Crisis in Medicare: Exploring the Choices, Rock Island, Ill., August 20, 1984.***

The Cost of Caring for the Chronically Ill.: The Case for Insurance, Washington, D.C., September 21, 1984.***

Discrimination Against the Poor and Disabled in Nursing Homes, Washington, D.C., October 1, 1984.***

Women In Our Aging Society, Columbus, Ohio, October 8, 1984.***

Healthy Elderly Americans: A Federal, State, and Personal Partnership, Albuquerque, N. Mex., October 12, 1984.***

Living Between the Cracks: America's Chronic Homeless, Philadelphia, Pa., December 12, 1984.***

Unnecessary Surgery: Double Jeopardy for Older Americans, Washington, D.C., March 14, 1985.***

Rural Health Care in Oklahoma, Oklahoma City, OK, April 9, 1985.***

Prospects for Better Health for Older Women, Toledo, OH, April 15, 1985.***

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Pacemakers Revisited: A Saga of Benign Neglect, Washington, D.C., May 10, 1985
The Pension Gamble: Who Wins? Who Loses? Washington, D.C., June 14, 1985***
Americans at Risk: The Case of the Medically Uninsured, Washington, D.C. June 27, 1985***
The Graying of Nations II, New York, New York, July 12, 1985
The Closing of Social Security Field Offices, Pittsburgh, Pennsylvania, September 9, 1985***
Medicare DRG's: Challenges for Quality Care, Washington, D.C., September 26, 1985
Medicare DRG's: Challenges for Post-Hospital Care, Washington, D.C., October 24, 1985
Medicare DRG's: The Government's Role in Ensuring Quality, Washington, D.C., November 12, 1985
Challenges for Women: Taking Charge, Taking Care, Cincinnati, Ohio, November 18, 1985
The Relationship Between Nutrition, Aging and Health: A Personal and Social Challenge, Albuquerque, New Mexico, December 14, 1985

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